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by

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THOMAS MATHAI PALAKKAMANIL

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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DEDICATION

This thesis is dedicated to my parents, Mammen Mathai and Annamma Mathai for their encouragement and to my wife, Miriam, for her constant support and patience.

ABSTRACT

In developing countries, approximately 70% of the total population live in rural communities. The formal health care system till now has been able to reach only a very small segment of the rural population. The efforts, made by the government, by international organisations like the W.H.O. and the PANAM, and by religious organisations, to uplift the health status of the rural population through the implementation of rural health programs, have been only minimal.

This thesis critically evaluates the existent community development and primary health care programs in developing countries with particular reference to India. In doing so, the study examines how primary health care programs can be better implemented (to meet the health needs of the rural people) through organised community efforts, using the resources available at the community level. Through this process, the primary health care system would be shaped around the life patterns of the people, reflecting the socio-cultural, economic and political characteristics of the country and its rural communities. Finally, due recognition would be given to the indigenous systems of medicine which have been practised for centuries by the rural population in most developing countries.

If primary health care programs are implemented through this process, what can be hoped will be achieved is, rural

communities of the developing world having access to the basic health services by the year 2000.

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CHAPTER 1

INTRODUCTION

This thesis is based on the old definition of public health given by Winslow 62 years ago, strongly underlining the importance of organized community efforts:

> Public health is the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity (Winslow, 1920).

Primary health care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least:

1. Promotion of proper nutrition and adequate supply of drinking water;
2. Basic sanitation;
3. Maternal and child care, including family planning;
4. Immunization against major infectious diseases;
5. Prevention and control of local endemic diseases;
6. Education concerning prevailing health problems, their prevention and control; and
7. Appropriate treatment for common diseases and injuries.

In order to make primary health care speedily accessible to the community, full community participation in the planning, organization and management of primary health care, as well as maximum community and individual self-reliance are required. Such participation is best mobilized through appropriate education, enabling communities to deal with their health problems in the most suitable way. They will thus be in a better position to make rational decisions concerning primary health care and to make sure that the right kind of support is provided by other various levels of the national health system. These other levels have to be organized and strengthened so as to support primary health care with technical knowledge, training, guidance and supervision, logistic support, supplies, information, financing, and referral facilities including institutions to which unsolved problems and individual patients can be referred. The term "community development" is not always understood by those engaged in rural health activities.

Community development is a specific approach, a pattern of well established practices emanating from certain basic principles, attitudes and objectives whose implications, however, are frequently unfamiliar to health personnel working in close proximity to rural health activities in operation.

Strategy For Introducing Primary Health Care

Strategies currently emerging to alter the imbalance between health care needs and health care resources emphasize the development of primary health care systems based on community development programs.

The World Health Organization (WHO) has already confirmed its intent to co-operate in the development and strengthening of primary health care systems. Its stated goal is that all people in the developing world will have access to basic health services by the year 2000. Particular emphasis is being placed on the establishment and maintenance of a health care infrastructure at the community level, which will provide continuing basic health services for major health problems. Within this structure, people served will be closely involved.

The WHO is strongly committed to community development (rural development in most cases), strengthening the community and its ability to handle its own problems. Community development programs have important implications for health and health care services.

Firstly, community development programs contribute directly to the increased well-being of the community. Improved roads, transportation and communication systems, for example, reflect on the economy of the community (with which health status is strongly correlated) and on the health care people can obtain; improved agricultural practices, which have an economic as well as nutritional impact; small industry, which provides jobs and cash flow with a subsequent improvement in living standards. Conversely, health care services contribute to further development. Healthier people can invest more energy in working and learning, and can thus upgrade their own communities.

Secondly, the involvement of people in the planning, development and management of programs is an important factor in improving the general standard of living. Participants are able to put their knowledge, skills, sophistication, self-reliance and motivation gained, to the solution of community problems directly related to poor health. Community development programs thus, include direct involvement in the health care system of the community, which is of crucial importance if health services are to be understood, accepted, and be compatible with community desires. This participation also provides a new resource - people who contribute their energy and time in order to strengthen health services - a resource which health care cannot do without, if it is to extend its services more broadly.

The third way to shift the balance between available resources and health care needs at the community level in developing countries is to ensure that every action taken and every technology used realizes its potential for effectiveness to the fullest degree possible, while at the same time being affordable, usable under the circumstances of delivery, and acceptable to the accompanying methods, techniques, instruments, and supplies made to meet these four criteria.

Coverage should be extended to a greater number of people. Persons who work at the village level, often with little training and inadequate supervision, could be expected to work more easily, effectively and safely.

Community participation, as part of the community development process, becomes more of a possibility, as basic economic and educational levels keep rising. Village improvements in many countries of the world, during the past generation, have worked to the advantage of the community development approach. Although nearly half of the world's population live in absolute or relative poverty, observers who have had continuing contact with the rural scene during recent decades can appreciate the changes that have taken place. In villages throughout the world, education is more productive, the standard of living is higher, roads have been built, and the transistor radio is a commonplace item. The villager too is a different person. His horizons have become broader, he has travelled to cities and has perhaps even worked in them. He is also less suspicious of his neighbours. It appears, then, that the contemporary villager is more ready to collaborate in development activities, including primary health activities, than was his counterpart a few years ago.

This "people-oriented" model, as opposed to the narrower techno-economic "growth-oriented" model, is more therapeutic since the majority of people participate in the planning and execution of development activities.

The Comprehensive Community Approach To The Rural Health Problems in Developing Countries - A Model

There are many factors which influence the health status of any community population. Direct influences include: environmental conditions (physical and preventive) and curative activities carried out by the community. These activities are influenced by the availability and utilization of health services within the community. Utilization is influenced by environmental conditions and socio-cultural and economic factors.

The importance of economic conditions may be noted. Through nutrition, for example, poverty influences the health status of any community, both directly and indirectly. Indirect effects include inadequate utilization of health services. For example, even though services may be free, people may not be able to reach the health centers for the simple reason that they cannot afford the bus fare. Similarly, economic conditions will affect the physical environment through poor sanitation. The socio-cultural environment will also be affected, as people who are very poor, tend to be more traditional and less willing to try innovative ideas because they cannot afford to risk losing what little they have. Since economic conditions are of such great importance, health programs should therefore be closely linked with community development programs. Above all, the political facet, the primary decision making component of all communities, should encompass the very dynamics of development.

Another very important factor is that of utilization, with which health education is chiefly related. Even if health services are available, they will have no effect unless properly monitored. As already mentioned, utilization will be influenced by physical, economic and socio-cultural conditions. The latter seem to be particularly important and require effective communication. This influence should be two-way: utilization of services should in itself be a learning experience which modifies people's attitudes.

Purpose Of The Thesis

Studies, in developing countries, indicate an uneven distribution of medical and health services. Various researchers have offered alternative approaches, strategies, and programs to rectify this imbalance. Based on these reports, programs have been launched in India by the government as well as by international health organizations which, however, have been unable to meet the basic health needs of the rural population. Dr. Halfdan Mahler, Director General of the WHO, said that "health for all by the year 2000" will not be achieved unless effective, low cost health care is put into practice and untapped manpower and other resources available at the community level are made use of through community development programs in developing countries.

The main purpose of this thesis is to examine how the community development process influenced primary health care programs in India through organized community effort. The thesis will investigate:

1. A description of community development (rural development) programs in India;
2. A discussion of primary health care programs in developing countries;
3. Health and its multiple relationships to the various aspects of development;
4. Community involvement in the planning and implementation of national health care as well as of local primary health care activities and programs;
5. The utilization of available community resources, e.g. traditional medicine in primary health care activities;
6. Community participation; and
7. People's involvement in health care programs.

Research Methodology

The methodology used in this thesis is historical and analytical in nature. It will include an analysis of the existing data on community development theory and a similar analysis of primary health care programs in developing countries with special reference to India.

The main theme of this research is focused on how the community development process can influence the community's health care system utilizing all available resources. In the process, an effective primary health care system, shaped around people's life styles and patterns, will be organized. The theoretical framework of the developing countries' rural population and their social needs will be drawn from the works of Maslow, Ensminger, Biddle and Biddle, Banerji, Levin and Newell.

The community development approach states that it is important to obtain the participation of the people to help them reach a decision by democratic methods, taking as much responsibility for the project as possible and working it out in their own way. There is a hidden assumption here, that the basic values of the community are similar to those of the health workers and that, if they understand the need and are allowed to use their own methods of bringing about change, people in the community will themselves work towards the goals desired by the health team, whose only role will be that of enablers, encouragers, and facilitators. Some would go further and say that community members themselves should set their own basic values and goals, and that outside agents (government or international organizations) should not interfere. This would place outside agents in the position of observers rather than of community health developers. It is assumed here that it would be more desirable that outside agencies play multi-faceted roles rather than merely that of observers.

The aim of this historical and analytical exporation of the existing data on the process of community development in primary health care, is to gain some insights into a comprehensive community approach to the rural health problems in developing countries. The purpose also is to point out why primary health care fell short to meet the health requirements of the rural masses of India. This would allow recommendations, to improve the existing primary health system, to be made.

Review Of The Literature

Community development has been effectively used in many countries as a way of improving the health of the people. Popular participation in development is now an internationally accepted strategy and, in some countries, communities have applied this strategy in the form of specific community development programs to improve health.

The WHO's various publications provide significant information about community involvement in primary health care programs. In every case, the formation, recognition and strengthening of local community organizations were crucial.

In 1954, the WHO Report on Health Education (TRS 89)' did not emphasize the need for any specific knowledge of the community development approach. However, by 1958, a further report in the series (TRS 156)' pointed out that training in health education should be made available to workers in other fields, including community development, and that health workers should have the responsibility to assist in community development programs. Thus, in four years, community development had not only been recognized, but special training in this field was felt to be an essential part of the training of all health workers.

In some developing countries, the community development approach has, in fact, been used in many rural health improvement activities such as, for example, in the well and latrine construction projects. This approach, however, has never been used extensively in its comprehensive sense. Rather, a few techniques have been "borrowed" in order to achieve certain health objectives. There is evidence to suggest that today, where community development does form a part of rural health activities, it is usually regarded as being distinct from them and slightly oblique to health activities. For example, in the Korean rural health project, "a community development effort (was envisaged) to encourage the local residents to participate in co-operatives and other self-help projects"' and in the Nicaraguan rural health project, "community development workers are trying to create an awareness of the possibility of progress to replace the apathy which is at present a brake to development."[4]

In 1977, the UNICEF and WHO study pointed out that the strategy adopted for accomplishing primary health care to all underserved populations, through the integration of resources at the community level, both human and material, needed to make an impact upon the health status of the people. The approach emphasizes the need for community involvement in the general development process - a process by which better health can and should be both an ingredient and a derivative. In communities where material resources are scarce and human resources abound, this strategy, basically one of self-reliance, is probably the only approach that these communities can afford, and it could well turn out to be the most cost-effective.[5] Based on the general concepts of M. Ross,[6] Biddle,[7] Biddle,[8] Clinard,[9] and the International Cooperation Administration, the United Nations Department of Economic and Social Affairs, and the XI International Conference on Social Work, community development can be viewed as an educational, problem-solving process designed to help a community solve its problems through group decision making and group action.

The development of an effective system of primary care based on concepts of western medicine is unlikely to succeed, if it ignores the existing patterns of health culture in the community. In India, the village concepts of the etiology of disease, its appropriate treatment, and utilization patterns of the formal health system and its alternatives, have been studied by a number of authors Bodding 1925,[10] Bodding 1927[11], 1940[12] (Journal of Asiatic Memories), Carstaris 1965,[13] Marriot 1965,[14] Marwah and Kocher 1978.[15] Different surveys, (Rao et al 1973,[16] Marwah et al 1978,[17] Chakravarty 1972,[18] John Hopkins University 1970[19]) indicate that only about ten percent of all sickness episodes are seen by the government primary health centres and sub-centres in the rural areas.

One of the principal reasons for this is that, in India, a large number of alternative sources of health care are available to the villagers, from the private practitioner who has been wholly or partly trained in western medicine, formal eastern alternatives, or the village folk practitioner. The latter are part-time curers who have had no formal training, yet they treat about 40 percent of all sickness episodes in the rural areas (John Hopkins University, 1970).[20]

The WHO/UNICEF Joint Study on Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries very strongly enunciates a maximum utilization of the available community resources through community participation, as well as their integration with other sectors of community development such as agriculture, education, public works, housing, and communication (1977).[21]

Footnotes

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CHAPTER 2

WHAT IS PRIMARY HEALTH CARE?

The term primary health care evokes a variety of definitions influenced by conceptual differences, professional training and interests, as well as the past and present socio-economic, cultural and political systems of each country. Primary health care as adopted in the Alma Ata Conference is defined as "essential health care based on scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the sprit of self-reliance" (WHO, 1978).[1] Structurally, primary health care is an integral part of the national health system, it being the essential function of both the health system and the overall community development. It constitues the first level contact of individuals, families and communities at the periphery.

In this definition, there are four essential features, of Primary health care which are significantly different from the conventional medical care systems. They are:

1. The effective co-ordination with the social, economic and related health services to help people deal with the

many-sided problems that affect health.

2. Its stress on the importance of health promotion and development and of increasing the capability of people to live a healthy life.
3. Promotion of personal and community responsibility and involvement in their own health care.
4. The measures and activities undertaken at the level of first contact with individuals, families, and communities for the care and prevention of diseases, disability and dependancy, rehabilitation and promotion of health.

Primary health care touches multi-faceted problems of the daily living of individuals and communities which require knowledge, attitude and skills not only in promotive, preventive and curative dimensions of health care but also in socio-economic dimensions that include skills in organized community development.

Concept Of Primary Health Care

The concept of primary health care is misunderstood if it is seen merely as the first contact between a sick person and some representative of the formal health care system. It is grossly misunderstood, of course, if it it thought of as a second class substitute for "real care" to be applied only in developing countries. Primary health care consists of those basic health measures which should apply to all people in both developing and undeveloped countries alike. The declaration of Alma Ata holds that primary health care addresses the main health problems in the community, providing promotional, preventive, curative and rehabilitative services. As such it includes;

> "education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of common diseases and injuries and provision of essential drugs" (WHO, 1978).[3]

In developing countries, adequate primary health care may require the provision of services where none at present exist. In developed countries, it may require the re-focusing of existing services and a re-ordering of priorities. In all countries, it requires the formation and implementation of programs for health development, which include, among other things, the assumption that there will be substantial community participation.

During the last several years "primary care" has come to the fore as the "new" priority in health care. In September, 1978 the World Health Organization and UNICEF jointly sponsored the first international conference on Primary Health Care which was held at Alma Ata in the Soviet Union. (For the Declaration of "Alma Ata" see Appendix 1.)

Of course, the idea of primary health care itself is not new. What is new is the priority such care should receive, now that the international health care community has agreed on its importance. The significance of this recognition is great and reflects not onlya growing understanding of the technical, economic and social issues involved but, even more important, an evolving of the political and economic relationships both within and between nations that have taken some sharp turns during recent years.

Rationale For Implementing Primary Health Care

To varying degrees, virtually all the nations comprising the "First World" of industrialized, capitalistic countries are suffering from declining economic growth, relatively rapid inflation and considerable umemployment. Such economic problems inevitably carry with them certain political concerns. Most of these countries also feel the pinch of rapidly expanding and apparently uncontrollable health sector expenditures. To add insult to injury, so to speak, these expenditures are increasingly being seen as having little positive measurable impact upon even improving national health indices. Some critics have even suggested that these increased expenditures are actually contributing to ill health.

Not surprisingly the health sector in most countries including those of the Third World, follows closely the socio-political characteristics of the nation. As such, the health sector in most Third World countries is characterized by services directed toward the wealthier members of the population, and which conform to the requirements of the most elite group of health care providers, the medical profession. Coverage of the population of even elementary health care services is often no greater than a quarter of the whole, and by effective and "caring" services, it is even less (Newell, 1975).[3]

A grave imbalance exists between the overwhelming needs of the people and the capacity of available health care resources to meet them. This imbalance is, of course, familiar to all who have worked in developing regions of the world. On one side of the scale, is the overall blanket of poverty, the large majority of the population living in rural or remote areas, the high percentage of children and youth with special needs, and the high prevalence of illness and early death, for individuals and families living in rural poverty, as well as for the poor living in urban and periurban fringe areas. The conditions of life are such that the development or maintenance of health becomes almost an impossibility. Environmental sanitation, including clean water, a basic necessity for health maintenance, cannot be ensured. Nutritional well-being, the other major determinant of good health, is difficult to achieve. Families have little opportunity for education, or for acquiring the sophistication required to cope more effectively with the deleterious conditions under which they live. The wide prevalence of chronic malnutrition allows little room for energy expenditures over and above those needed for existence.

Because of the great inadequacies in the basic health and life sustaining necessities, the poor in developing countries suffer great burdens of disease, disability and death. Life expectancy is low and one half of all deaths usually take place in the under five age group. More than 97 per cent of all under five deaths occur in the less developed countries (Naverro, 1974).

In most countries of the less developed world, resources for health, financial manpower, facilities, planning and research, tend to be in the cities and large towns, and within the urban areas tend to be put to use at the most complex level of care. It is the hospitals and medical centres, caring for the few with diseases requiring the most complex technology (and tending to care for the most part for those geographically closest to the facility), which have the greatest access to the resources of the country. This disparity in resource allocation between urban and rural areas and between primary care system and the tertiary level is also characteristic of many developed countries. Because there is more money to spread around, however, the absolute level of expenditures for rural primary health care becomes less abysmal. This concentration of resources on the more complex services and facilities derives, at least in part, out of the medical profession's overwhelming pre-occupation with scientific medicine and with technology itself, and out of human pro-activity, often characteristic of those involved in political matters, to spend money for the largest, the "best" the "highest" quality and the "most advanced". The less visible primary level from its most peripheral point in the village, is the larger health centres, they being seen too often as not exemplifying those attributes, and as a result, tending to suffer from financial undernournishment, underdevelopment and neglect (Naverro, 1974).'

Primary Health Care In India

Historically, the experience and concern in the field of primary health care in India dates back to the Vedic period. As far back as 3000 B.C., the Indus Valley civilization had already developed environmental sanitation programs such as provision of underground drains, public baths, etc. in the cities.

'Arogya' or health was given high priority in daily life, and rules set and advocated for attaining 'arogya' indicate that the concept of health was not limited to the state of absence of disease, but included physical, mental, social and spiritual well-being. The concept of primary health care for all has been aptly and beautifully expressed in an ancient sanskrit verse: (Sarve Santu Niramayaha). Literally it means, "Let all be free from disease."

The life style that was evolved was conducive to health promotion. The essentials for health care, eg. personal hygiene and habits, health education, exercise, code of conduct and self-discipline, dietary practices, food sanitation, environmental, civic and spiritual values, treatment of minor ailments and injuries, etc., were neatly woven into the daily activities of life, or what was called 'dina charya' (Rao and Radhalakshmi, 1960)[6]. Through such practices and traditions, the community was self-reliant in health matters generally. The society also cultivated the science of life, Ayurveda. By 1400 B.C. total health care with emphasis of health promotion and health education was the main feature of Ayurveda. In spite of the stress on prevention of disease, curative medicine was also well advanced at that time.

Unfortunately, for unknown reasons, this great era was lost to a dark age. There were further onslaughts because of a series of foreign aggressions and regimes leading to a greater disruption of the existing health practices, which were a part of social and cultural interactions and exchanges. Ayurveda not only failed to develop, but also languished because of a want of an adequate state of patronage and recognition (Banerji, 1976).[7] What survived were the anthropological evidences, a wealth of vedic literature, yoga exercises, traditions, and customs. Of special significance are the traditional recipes consisting essentially of mixtures of locally grown cereals, herbs, pulses, etc., which for all their antiquity are now seen to be scientifically and nutritionally sound. Another good example is the waning custom of observing 'sovle' - a type of isolation or sanctity - as a part of food hygiene, etc., and of 'sutak' - a kind of quarantine - to be observed for a specific period in the event of death in a family. These customs had unquestionably originated as aseptic techniques without which the surgical procedures would never have been successful in the days long before those of Lister in the United Kingdom and Pasteur in France.

The Western Influence

During the middle of the eighteenth century, the alien British government in India established medical services essentially for the benefit of the British nationals, the armed forces, and the privileged civil servants. But the vast majority of the native population was denied access to Western medicine. The Ayurvedic, unani, and other local health care facilities were totally neglected and allowed to languish. The services were largely curative for the care of the sick and injured, and were available at the general hospitals located in the big cities and commercial centers (Banerji, 1976:14).' Later, some preventive measures were provided for the control of epidemics, and dispensaries were opened in some remote villages. Provincial health departments were established in 1919 (Grant, 1943:12).' But neither health planning nor medical education was based on the health needs of the people. The medical colleges and schools produced physicians who were trained in hospital-based curative medicine. In complete ignorance of community-based health care, they were brought up in the colonial tradition of the hospital services, mostly catering to people from the upper classes in the urban areas (Government of India Report, 1946).'* This strong western bias was largely responsible for the blind adoption of sophisticated "modern medicine" for a few. Techniques and drugs were not critically evaluated were and are being used indiscriminately. High technology was accepted without cost-effectiveness analysis and relevance to health needs. The resultant lopsided development of health services significantly slowed the speed of providing essential health care to the rural population and the urban poor.

The Health Situation, After Independence

India is a vast country with an area of over 3.29 million square kilometers and a population of 683.8 million by the 1981 census. A little less than 80 percent of the population is rural and lives in about 580,000 villages. About half of the villages have a population of 500 or less. It is estimated that from 15 to 20 percent of the population is undernourished and many more are below the poverty line (Government of India Report, 1961).'' The literacy rate is 36.2 percent. The health conditions in the country were precarious before independence.

In 1947, a planned program for the nationwide provision of medical and health services to the people was started as part of developing a welfare society. On the eve of Independence, the Health Survey and Development Committee, popularly known as the Bhore Committee, had submitted its report. This classic report provided an almost revolutionary alternative and furnished a blueprint for a new approach to the health services in India. It is one of the most rational and far-sighted documents of its kind. The national government readily accepted the report as it was based on guidelines which were similar to those put forth by the National Planning Committee of the Indian National Congress in the thirties. The important innovating recommendations of the committee were:

1. Establishment of an effective rural health services infrastructure by creating a network of primary health centre complexes.
2. Provision of integrated preventive, promotive, and curative services with full participation of the people.
3. Reduction in the size of each family unit, (through family planning) for a healthier and happier life.
4. Provision of adequate health and medical care even to those who are unable to pay.
5. Training of necessary health manpower, medical, nursing, paramedical, and auxillary (Government of India Report, 1961).''

It was accepted and provided for in the constitution of India that the health of the people is the responsibility of the state.

A planning committee was set up in 1950 for socio-economic development; and for the implementation of the health program which was to be initiated in the successive five year plans. The Community Development Program was launched in 1952 with the objective of integrating rural development in all the sectors simultaneously. The comprehensive health services which were to be provided through the primary health centres formed one of the components of the all-round development activities.

India's New Approach To Primary Health Care

Major steps towards providing integrated health care were taken during the fifth-five year plan. The emphasis was on the provision of a packet of integrated health, family planning, and nutrition services to the vulnerable groups, they being, the children, pregnant women, and nursing mothers. In order to rectify past shortcomings, such as the failures of the national health programs, ineffective co-ordination in the nutrition programs, and the slow rate of development (as a result of interdependence of different sectors), it was necessary to improve the health infrastructure and to launch a frontal attack on poverty. Not only had there been much proliferation of special cadres established under each program eg. smallpox, malaria, leprosy, tuberculosis, cholera, trachoma, family planning, etc., but there was also a clash of interests, shortsightedness, and a tendency to work in mutually exclusive compartments. Thus, a Minimum Needs Program was introduced in the fifth plan as a corrective measure. The components of the program consisted of elementary education, rural health, rural water supply, rural roads, house sites for landless, slum improvements and rural electrification. However, the targets were not fully reached and appreciable results were not evident.

In the health sector, a large number of staff, under the different national programs, were functioning in the same areas and serving a large population. This system was not cost-effective and was not satisfactory in many ways. In 1973, the committee, popularly called the Kartar Singh Committee, recommended that the health services be restructured. The committee suggested that the National health Programs - the Unipurpose Schemes - be integrated with the general health services infrastructure (Government of India Report, 1980).[13]

Thus, the Multipurpose Health Workers Scheme was proposed and approved by the government. This was indeed a big historical step in the evolution of a national health policy. It was planned to nationalize the organization, and use available manpower so as to reduce the area and population covered by each of the field staff in order to reduce travel time and to make services more effective and more satisfactory. Each multipurpose health worker was entrusted with the task of providing comprehensive health care to about 5,000 people instead of carrying out just one function such as malaria work or vaccination under a special program covering a population of over 10,000 people. The workers would also be better known to the people they served.

Under this scheme, the male health workers such as the smallpox vaccination workers, malaria surveillance workers, basic health workers, family welfare field workers/health assistants, cholera workers etc., were unified into one body and were redesignated as health workers. The auxillary nurse-midwives, etc., were also designated as health workers (female). The existing supervisory staff eg. sanitary inspectors, smallpox supervisors, health inspectors, malaria inspectors, leprosy technicians, etc. were brought under one head and re-designated as health assistants (male). They were assigned the task of guiding and providing technical support and supervision over every four health workers (male). Similarly, four health workers (female) were guided and supervised by health assistants (female), previously a nurse midwife, general duty nurse, or lady health visitor. A team of one male and female health worker was to deliver the package of primary health care to a population of 5,000.

An intensive and massive training program had been undertaken to convert the multipurpose health personal into multipurpose workers. As of January 1, 1981, out of a total of 401 districts in India, 210 had been covered and re-orientation training programs had been completed for 2,156 district level staff and key trainers, 9,172 medical officers working at the primary health centres, and 137,871 male and female health workers and health assistants. Training was carried out in 142 districts for their respective health personnel. The balance of 49 districts was scheduled to be covered in the last phase (Government of India Report, 1980).[14]

Medical education was also under review, as the system failed to provide adequate community based and health oriented training to the doctors. The Medical Education and Support Manpower Committee, popularly known as the Srivastava Committee, reviewed the entire situation and submitted its report in 1975. It strongly recommended the quicker implementation of the Multipurpose Workers scheme and the introduction of a three tier plan for health care in the rural areas, eg. - village-level volunteers, intermediate-level paramedical staff, and primary health centre-level medical and referral services. Acknowledging the enormous significance of community participation, the committee put forward the revolutionary concept of using the people to improve their own health, and suggested the creation of bands of paraprofessional or semiprofessional health workers from the community itself to provide primary health care in the villages. Such workers were not to be part of the formal health services (Government of India Report, 1976).[15] The committee also proposed a plan to re-orient medical education and shift the emphasis from "hospital care" i.e. "care", to "community care" i.e. prevention of disease and promotion of health.

Footnotes

1 Alma Ata, International Conference on Primary Health Care. Alma Ata. U.S.S.R., September 1978, WHO Report. 2

Ibid.

3 Newell, R.W. (Rd). Health By The People. WHO, Geneva, p. 34, 1975.

4 Neverro's Seminal Contribution. The Underdevelopment of Health on Health Development. Int. Journal Health Service, p. 257 and 258, 1974.

5 Ibid.

6 Rao, M.N., and K.K. Radhalakshmi. History of Public Health in India, Calcutta : Novana Printing Works, Private Limited, pp. 66, 1960.

7 Banerji, D. Formulating an Alternative Rural Health Care System for India. New Delhi: Centre of Social Medicine and Community Health. Jawaharlal Nehru University, 1976.

8 Ibid, p. 14.

9 Grant, J.B. The Health of India. Oxford Pamphlets on Indian Affairs, number 12. London: Oxford University Press,

p. 12, 1943.

10 Government of India. Health Survey and Development Committee: Report, Volume 4. Delhi: Manager Publication, p. 14, 1946.

11 Government of India. The Health Survey and Planning Committee: Report, Volume 1. New Delhi: Ministry of Health. p. 90, 1961.

12 Ibid, p. 78.

13 Government of India. Pocket Book of Health Statistics in India, New Delhi: Central Bureau of Health Intelligence. Ministry of Health and Family Welfare, p. 9, 1980.

14 Ibid, p. 27.

15 Government of India. Group on Medical Education and Support Manpower Report: Ministry of Health and Welfare Planning, p. 31, 1976.

CHAPTER 3

INDIA'S NEW APPROACH IN RURAL HEALTH CARE

A number of surveys on health facilities in rural India reveal that India is still lagging much behind the target. The Health Survey and Development Committee headed by Dr. Bhore and known as the Bhore Committee (1946) and the Health Survey and Planning Committee headed by Dr. Mudaliar and known as the Mudaliar Committee (1961) have given definite guidelines on health planning in India.

The objectives of health programs during the first four five year plans were (1) control / eradication of major communicable diseases, (ii) provision of curative, preventive and promotional health services, (iii) augmentation of training programs of medical and para-medical personnel; (iv) and strengthening of the primary health centre complex for undertaking preventive and curative health services in rural areas. The Fifth Plan tried to provide minimum public health facilities integrated with family welfare and nutrition for vulnerable groups - children, pregnant women and nursing mothers. The accent of the schemes during the period has been on (i) increasing the accessibility of health services to rural areas, (ii) intensification of the control and eradication of communicable diseases, especially small-pox, malaria, leprosy, (iii) qualitative improvement in education and training of health personnel, and (iv) attempts to develop referral services by providing specialists' attention to common diseases in rural areas. Unfortunately, the achievements during the plan period fell short of the targets, especially in the Minimum Needs Program, whose objectives were to create an adequate infrastructure and efficient health care services in rural areas. (Minimum Needs Program lays down the urgency for providing social services according to nationally accepted norms within a time bound program).

The Fifth Five Year Plan stressed the importance of Health Services to rural India. Quite ambitiously the planning commission declared, "The primary objective during the Fifth Plan is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups - children, pregnant women and lactating mothers. It will be necessary to consolidate past gains in the various fields of health, such as communicable diseases, medical education and provision of an infrastructure in the rural areas. The accent during the Fifth Plan will be on (i) increasing the accessibility of health services to rural areas, (ii) correcting the regional imbalance, (iii) further development of referral services by removing deficiencies in district and sub-divisional hospitals, (iv) intensification of the control and eradication of communicable diseases especially malaria and smallpox, (v) quantitative improvement in the education and training of health personnel, and (vi) development of referral services by providing specialists' attention to common diseases in rural areas.

"The minimum needs program, along with the training of multipurpose health auxiliary and a more vigorous pursuit of communicable diseases eradication / control is the core of the health care programs. Backward and tribal areas which have so far been neglected will receive preferential treatment in the implementation of the health programs" (Draft Fifth Five Year Plan, 1974-79 Vol.II).'

Salient Features

The salient features of the Minimum Public Health Needs Program as enunciated by the Fifth Five Year Plan were: The Minimum Needs Program was to receive the highest priority and to be the first charge on the development outlays under the Health Sector. The targets were: (i) one primary health centre for each community development block, (ii) one sub-centre for a population unit of 10,000, (iii) making up the backlog and deficiencies in buildings, staff, equipment etc, (iv) provision of drugs at the entranced level of Rs. 12,000/ - per annum for primary health centre and Rs. 2000/-per annum per sub-centre, (v) upgrading of one in four primary health centre's to 30 bedded rural hospitals.

Existing curative establishments such as dispensaries, cottage hospitals etc., were to be functionally integrated with the primary health centre complex:

"To ensure their more effective functioning, primary health centre's which at present do not have adequate road communications, safe drinking water supply and electricity, will be provided these essential amenities under the Minimum Needs Program on a high priority basis. The same consideration will apply in the location of new PHC's. In effect, to make a better impact, the minimum needs program will be offered as a package consisting of health care, potable water supply, adequate road communication and rural electrification.

"The rural hospital establishments are expected to provide routine specialised services in medicine, surgery, and obstetrics and gynaecological disciplines. Adequate provisions will be made for care of emergencies and acutely ill cases refered from the neighbouring PHC's. These establishments will provide relief to the currently overcrowded district and other hospitals and will thus bring expert medical care within the reach of the people residing in rural areas.

"A sizeable component of the outlays on minimum needs program is for the provision of drugs at sub-centre, primary health centre and rural hospital level. The endeavour during the Fifth Plan will be to make essential drugs available to the rural areas at cheap prices.

> There were doubts about solution of the rural health problem. Experiments proved less effective and expensive. There was too much of emphasis on Western model was derived by experts. It was realized that "it is this model which is depriving the rural areas and the poor people of the benefits of good health and medical services. Serious doubts have, therefore, been raised as to whether India did right in adopting this western model of medical services and health care whose costs go far beyond India's resources, which emphasizes curative rather than preventive and promotional aspects and which creates immense problems because of over emphasis on inappropriately high level professionalisation, institutionalization and centralization" (Draft Five Year Plan 1978-83, p. 230).[3]

Dr. Srivastava's committee analysed the problem with a practical approach. The angle was on the availability of medical resources in the villages rather than on placing a more theoretical blue print. It was the first offical committee to take this into account and to suggest a new approach to health care services which begins with the community and trained health workers from within the community itself and then links up these basic services within the community with an infrastructure of dispensaries and hospitals through a sound and well-organized referral system. This basic recommendation of the committee was immediately acted upon by the Government in October, 1977, and steps were initiated to augment the health care facilities in the rural areas through (i) a scheme of transferring skills to workers selected by the community under the new community Health workers' scheme, (ii) drawing up a scheme of involvement of medical colleges in the total health care of selected primary health centres with the objective to re-orienting medical education and making specialist services available to the rural public and (iii) accelerating re-orientation training of unipurpose workers engaged in the control of various communicable diseases programs into multi-purpose workers so as to integrate the present vertical structure for control / eradication of communicable diseases.

"Prevention is better than cure" was the main motto of the new policy. The main objective was, "to serve the rural areas and poor people. The policy visualizes the development of a large band of health workers from the community itself to take care of the common day-to-day ailments, which make even the best medical aid, available to every individual through a well-organized referral system and through a chain of taluka, district and state hospitals,[1] costs remaining within the reach of India's resources.

The most important recommendation of the Srivastava Committee was that primary health care should be provided within the community itself through specially trained health workers so that the health of the people is placed in the hands of the people themselves.

A scheme which came into operation soon after the Srivastava Committee's recommendation became public was the re-orientation of medical education, initiated with the twin objective of providing curative health care facilities to the rural people and giving a rural basis to medical education. Each of the 106 medical colleges in the country were provided with three mobile clinics obtained from the Government of the United Kingdom (Government of India, 1980).[3] The scheme provided for a one-time assistance to the medical colleges for meeting a part of the recurring and non-recurring costs, the State Governments meeting the additional non-recurring/recurring costs. The scheme will be continued in the plan and each medical college will cover a whole district in due course.

In the Fifth Five Year Plan approval was given for the positioning of one village Health Guide for every thousand villagers by March 31, 1984 (Government of India, 1981).[4] Mr. B. Shankaranand, Health Minister, made this announcement to the Member of Parliments attached to his ministry on December 16th, 1981. The job descriptions for each of the Village Health Guides were to: (1) treat minor ailments, (2) work for the control and eradication of malaria and other communicable diseases, (3) educate rural masses in maternal and child health care, (4) act as the focal point for the spread of family planning knowledge, and (5) sell oral and non-oral contraceptives.

Provision has been made for the establishment of a Village health Committee for each village. The committee would have five members chosen by the village community to supervise the working of the health guides. Qualified medical graduates will take up the task of trainings village Health Guides. Presently, India produces 13,000 medical graduates, 3400 practitioners of the Ayurvedic (traditional medicine), Unani and Sidha systems and 6,000 homoeopaths every year.

At present, there are about 140,000 community health volunteers in the field (as on 1st April, 1980).[6] During the 1980-85 plan it will be further extended to add another estimated 220,000 community health volunteers raising the total number to 360,000 by 1985. This will cover the whole country.

Indigenous And Western Systems Of Medicine In India

The terms "traditional" and "modern" are obviously value-laden. The term "tratitional" medicine will refer to what are called in India the "Indigenous Systems of Medicine" - the Ayurvedie, Siddha, and Unani Systems - and the folk medicine practices of various regions of the country. The term "modern" medicine will apply to the medical system which was mainly developed within the industralized countries.

In studying the development of the indigenous and Western systems of medicine in India, we would be indeed studying the political economy of the health problems and health practices in the country.

In the pre-industrial era of the history of man, different communities developed their health cultures in keeping with their overall ways of life. The more organized and refined the way of life of a community, the more developed was its health culture, and vice versa. However, since the way of life at this stage of man's history was by and large rather "simple", so was its health culture. The essential feature of health practices in the preindustrial era was that they were mostly evolved by the communities themselves, in response to the health problems they encountered, although there was some degree of diffusion of these practices to and from the health cultures of surrounding communities.

The Industrial Revolution brought about a very extensive and far-reaching disruption to this equilibrium, affecting the social, economic, and political relations as well as the health culture.

It is also significant that, when such widespread suffering created a political and social counter-reaction, and when it was realized that social problems were threatening industrial production and profits, the very same technological forces which had earlier caused this depredation were deployed by the captains of industry, who also had the political power to develop the western system. Economists, who had hitherto regarded medical expenditure as a mere consumption item, later came to realize that allocation to health care can also be an investment, an investment for increasing the productivity of labour.

Large masses of people became more impoverished through western ways, as a result of which, they were unable to maintain the health services which they had developed as a component of their overall way of life. "Unity of man and nature was the fundamental postulate of ancient Indian medicine".[6]

Indigenous Medicine And Primary Health Care In India

The development of an effective system of primary care, based on concepts of western medicine is unlikely to succeed, if it ignores the existing pattern of health culture in the community. In India, village concepts of the etiology of disease, its appropriate treatment, and utilization patterns of the formal health system and its alternatives, have been studied by a number of authors (Bodding 1925, Bodding, P.O. 1925, 1927, 1940, Journal of Asiatic Memories, 10:3)[7] Carstairs, 1965:212[8] , Marriot,[9] 1965:71, Marwah and Kockar,[10] 1978, 10:1). Different surveys (Rao et al 1973,[11] 27:512, Marwah,[12] et al 1978:17, Chakravarty,[13] 1972:19, John Hopkins University 1970)[14] indicate that only about 10 percent of all sickness episodes are seen by the government primary health centres and sub-centres in the rural areas.

Unfortunately, there is only limited data on the numerical strength of various types of medical practitioners other than those practising modern medicine, but what is available indicates that their number is very large. In the Pakhowal Block in the Punjab for instance, indigenous practitioners population ratio was found to be 1:1500. They outnumbered doctors 10:1. Although international organizations such as the World Health Organization have been increasingly acknowledging the importance of the formal alternatives to western medicine (WHO 1977), they have been slower to recognize the need to analyze the role of the folk practitioners and the possibility of utilizing them in primary care and health education. In India, it was at the Hyderabad Conference on Alternative Approaches to Health Care in 1975 that such an approach was first seriously discussed (Kocher, 1977 ICMR Report).[15]

The Department of Preventive and Social Medicine at Banaras Hindu University has for some time been advocating this approach (Kochar et al, 1977, ICMR Report, Marwah and Kochar 1979, 10:1),[16] identifying and characterizing the folk practitioners in and around its semi-urban and rural paretive areas (Shukla et al 1975, Shulka 1978, Kochar 1979, Shukla et al 1978)[17] and carrying out pilot training projects with several types of practitioners (Wantamulte et al 1979,[18] Tandon et al 1979,[19] Sharma 1979,[20] p. 167).

The extensive use of these practitioners in most developing countries stems from their geographical availability. Formal health services treat five patients beyond a five kilometer radius (Alexander and Shivaswami, 1970:3).[21] The accordance of their explanations and treatment with the local health culture; their element of altruism - a snake bite curer, for example, will not only provide his services free, but will drop whatever he is doing to attend a patient, and will remain with him until the condition is resolved. Moreover, their attitude towards their patients is much more acceptable than that of many doctors; in one survey, villagers were asked if they would like the folk practitioners to receive a government stipend; the majority said no, a typical comment being that if they were paid, they would start to behave like government officials (Shukla et al 1978).[22]

It must be emphasized that these folk practitioners are ordinary villagers, recognized in the community as having greater knowledge of health and sickness than their neighbors. This expertise is learnt by word of mouth, and as much as is considered appropriate is passed on to their fellow-villagers. Not only does the folk practitioner have a key role in health education, but by giving them training, health information is being passed on to the village people themselves.

Developments In Traditional Medicine

Traditional and indigenous systems of medicine have persisted for many centuries, even in parts of the world where modern health care is available. In the last few years, however, the idea of mobilizing the manpower component of traditional medicine for purposes of primary health care, particularly in rural areas, has been gaining ground in many countries. The steps leading to WHO's program in traditional medicine is as follows:

A meeting on the training and utilization of traditional birth attendants was held in 1972 at WHO Headquarters to develop training programs and research studies that could improve the services of these workers in their respective communities.

In 1974 a joint UNICEF/WHO study (Djukanovic UNICEF/WHO, 1975, p. 9) on alternative approaches to meeting basic health needs in developing countries recommended that practitioners of traditional medicine, including traditional birth attendants, should be trained for the primary health care services. This recommendation was endorsed by the Executive Board in 1975 and by the World Health Assembly in 1977, when a resolution on the promotion and development of training and research in traditional medicine was passed by acclamation.

In 1976, WHO's Regional Committee for Africa had "Traditional medicine and its role in the development of health services in Africa," as the topic for technical discussion. (WHO Chronical, 1976, 30:511) In the same year the Regional Committee for South-East Asia adopted a resoultion calling for the promotion of traditional and indigenous systems of medicine in the Region. (WHO Chronical, 1977 31:48).

In June 1976, WHO established a working group in Geneva for the promotion and development of traditional medicine. Besides the co-ordination of activities relating to the subject, the program (prepared by the working group) had the following objectives:

To foster a realistic approach to traditional medicine in order to improve health care.

To evaluate traditional medicine in the light of modern science, so as to maximize useful and effective practices and discourage harmful ones.

To promote the integration of proven valuable knowledge and skills in traditional and western medicine.

Execution of the program will be effected in close collaboration with the WHO Regional offices and high priority will be given to primary health care in developing countries and to active community participation.

A questionnaire has already been designed for the collection of all available information concerning practitioners of traditional medicine, their training, and services to the community. The analysis of information collected, together with the result of surveys and research findings, will no doubt assist in the development of meaningful training programs for the various categories of practitioners of traditional medicine. Doctors, nurse/midwives, other health workers, and students of health sciences will all be encouraged to undergo orientation in traditional medicine where appropriate (IDRC Report, 1980,

p. 24).[23]

Multidisciplinary investigations into systems of traditional medicine will be encouraged, and special attention will be given to laboratory and clinical investigations for identifying effective remedies, prepared from plants, animal products, and mineral substances. Investigations will also be conducted into the psychological and anthorplogical aspects of traditional medicine, as well as the mechanisms of accupuncture and other healing methods.

Wherever possible, priority will be given to the promotion and development of useful local resources such as herbs for the production of medical substances; such action should effectively reduce the drug bills of many developing countries.

There are already indications of future breakthroughs in therapeutic and health care delivery, and these indicate the WHO's Director General's goal - total health care coverage for all people by the year 2000.

Footnotes

1 Government of India, Primary Health Care in India, New Delhi : Ministry of Health and Family Welfare, 1980, p. 30.

2 Government of India, Working Group on Health for all by 2000 AD. New Delhi : Ministry of Health and Family Welfare, 1981, pp. 117.

3 Indian Council of Medical Research. National Conference on Evaluation of Primary Health Care programs : Proceeding. New Delhi : 1980, p. 404.

4 Ibid.

5 Government of India, Working Group on Health for all by 2000 AD. New Delhi : Ministry of Health and Family Welfare, 1981, pp. 120.

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CHAPTER 4

THE INDIGENOUS SYSTEMS OF MEDICINE IN THE HEALTH SERVICES OF INDIA

Substantial historical evidence is now available to show that many centuries before Christ, Indian medicine had succeeded in making the momentous move away from the magico-religious therapeutics to rational therapeutics (Chattopadhyaya, 1977).[1] This ushered in a wide range of theoretical and practical propositions, which attained an astonishingly high level of development. Unity of man and nature was the fundamental postulate of ancient Indian medicine. There also is evidence that when certain political forces made Indian society hierarchical, the society is everything that was conducive to the growth and development of sciences-secularism, the rational processing of empirical data, and the uninhibited search for lows of nature (Chattopadhyaya, 1977).[2] The history of medicine in India before the advent of the British is an account of an encounter between the forces of obscurantism and the forces of reasoning. The decline in the social, economic, and political life in the country not only led to unfavorable shifts in the ecological balance, but also created a setting in which obscurantism gained the upper hand. Perhaps the lowest point of this ecological crisis was reached during the decline of the Mughal Empire in the second half of the 18th century, a situation which set the stage for the British conquest of India. Even during this period, the system of Indian medicine retained some fragments of its past heritage. For example, the surgeons of the British East India Company learned the art of rhinoplasty from Indian exponents of surgery (Basham, 1954).[3]

At the same time, as a result of the colonial policy of shifting state patronage from the indigenous systems of medicine to the western system, the already stagnant indigenous systems were caught in a whirlpool. Their very neglect accentuated their decline, and the decline, in turn, made it increasingly difficult for the indigenous systems to compete with the highly favored and rapidly flourishing western system of medicine in capturing the imagination of the newly emerging educated elites of India. Thus, at a time when spectacular developments were taking place in the different branches of the western system of medicine, the indigenous systems of medicine became dominated by persons with very limited competence, sometimes even by quacks and imposters, and the scientific bases of these systems became almost totally eroded. The resulting vacuum was filled by a variety of superstitious practices and beliefs in supernatural powers and deities.

Thus, not only were the Indian masses denied the benefits of the western medical sciences by their colonial rulers, but the total disruption of their way of life which was brought about by colonialism caused a disruption of the health practices which these people had developed in response to their health problems. Adding to all this, colonial exploitation of the masses created adverse environmental conditions which further accentuated their health problems. The increased number of diseases generated by the disruption of the ecological balance, the breakdown in pre-existing health practices, and the denial of access to the western system of medicine combined to worsen considerably the condition of the masses, making them even more vulnerable to exploitation. At the same time, their oppressors acquired additional strength by using the fast-developing knowledge of western medicine to avoid sickness and to obtain prompt and efficacious alleviation when they fell sick. The health services were thus used as a powerful weapon for the perpetuation of colonial rule and, after India became independent, were also used to perpetuate an unjust economic and social order.

This analysis of the social, economic, and political determinants of the indigenous systems of medicine in India places this system in an entirely different perspective. It is unfortunate that most social scientists who have studied the health culture of the rural population in India have been over-enthusiastic in discussing the superstitious health beliefs and practices of these people and have not paid adequate attention to the powerful social, economic, and political forces which were instrumental in causing the decay and degeneration of their health culture (Banerji 1975).[4] Worse still, even in their descriptions of the existing situation, they have betrayed a pronounced ethnocentric bias. Marriott's study of western medicine in a northern Indian village is an example. He describes in detail an incident wherein the only wage-earning son of a poor laborer did not accept the calcium lactate and shark liver oil prescribed by a doctor (who, incidentally, was a white man and a missionary) for his tuberculosis and instead incurred debt to buy a preparation of honey and gold which had been made and guaranteed by an indigenous practitioner. However, a carefully designed study (Banerji, 1963)[5] of the social epidemiology of tuberculosis in the rural Tumkur district in Karnataka revealed that more than half of the tuberculosis victims in the district visited a government institution of western medicine, where they were almost invariably dismissed with a bottle of useless cough mixture. It can thus be asked: who, in fact, is irrational - the people, or the practioners of western medicine? Similar results were obtained in an intensive study (Banerji 1973),[6] of the overall health behavior of rural populations which included 19 villages located in 7 states of the country studying a village in Tamil Nadu, (Djurfeldt, and Lindberg 1976)[7] came to a similar conclusion, though, as the authors themselves admit their study suffers from major methodological limitations, including choice of village, the mode of data collection and their interpretation; and the ethnocentric bias of the investigators.

After India's independence, a native ruling elite took power from the British. Conforming to what Gunnar Myrdal has called a "soft state", these new rulers made lofty egalitarian pronouncements but used essentially the same machinery bequeathed to them by the British to ensure that the fruits of independence would benefit them most and that they would be able to perpetuate their hold on the government. The new rulers promised to take active steps to make the benefits of health services available to the masses, particularly to the weaker sections. For this purpose, they also promised a revival and strengthening of the indigenous systems of medicine. In actual practice, however, they went on following the old colonial tradition of giving supremacy to the western system. In contrast to the rural health services system, the urban health system continued to receive much greater attention in the development of both curative and preventive services. Community resources were made available to establish a number of hospitals, many of which had the latest sophisticated equipment for providing intensive care, open-heart surgery, brain surgery, and cancer therapy services, on the model of the industrialized countries. The western industrialized countries also provided a reference frame for the institutions for education, training, and research. Personnel from these sophisticated, urban-based institutions remained heavily dependent on their counterparts in the industrialized countries. The latter actively encouraged such dependence by providing "technical assistance" in the form of training, consultation, and "cheap" text-books.

The political leadership and the health administrators sought to secure an aura of social legitimacy for their actions by pointing to some not very relevant social, cultural, and psychological issues raised by social scientists. Value-laden issues such as modernization versus traditionalism and urban culture versus traditional folk culture were used to justify the urban and the privilege based class orientation of the health services in India. It was claimed that the backward, superstition-ridden, uneducated villagers first have to be educated by corps of well-trained health educators from the cities who can impart the virtues of the "modern" health services, which carry with them all the trappings of dependencies, promotion and profit orientation (Banerji, 1975).

Because of the increasing tendency toward commercialization and professionalization of the health services in the affluent countries. which actively promoted dependence on health professionals, the elite-oriented services in India acquired these elements and in the process absorbed more and more of the resources. Excessive pre-occupation of the leadership at the political, bureaucratic, and technocratic levels with the urban health services system led to the neglect of the rural health services. Not only was the rural health service system starved of resources, but perhaps even more important, the technical content of the services and the "culture" and value system of the personnel of the rural system were often mimical to the needs of the rural population. Because of these factors, the rural health services could provide coverage only to a fraction of the rural population. Even for those that had access, the services were "handed down" and educators and motivators were employed to make people accept what was given to them.

As early as 1920, the Indian National Congress (which spearheaded the independence movement in India) passed a resolution to the effect that, considering the prevalence and generally accepted utility of the Ayurvedic and Unani systems of medicine, earnest efforts should be made to promote instruction and treatment in accordance with these systems (Government of India 1948).' However, after India became independent, the indigenous systems of medicine were subjected to contradictory pulls. The systems being firmly rooted in Indian culture for centuries and they being rich in heritage, invoked considerable admiration and even a certain degree of emotional attachment from a large section of the population. At the same time, long neglect of these systems of medicine led to a very sharp deterioration in their bodies of knowledge, their institutions for training and research, their pharmacopoeias and drug industry, and their corps of practitioners.

True to its "soft state" approach, the political leadership of the country paid lip service to the indigenous systems of medicine in order to gain popularity, while at the same time it vigorously expanded the western system of medicine, which was much more in tune with its class interests. Investments in the indigenous systems of medicine were almost negligible compared to that in the western system. A much more serious aspect of this approach was that, unlike the case of China, the indigenous systems of medicine were never taken seriously by the political leadership, and very half-hearted and obviously superficial efforts were made to conduct research to rediscover their lost heritage, to get rid of the obscurantist elements that had crept in, and to promote further growth and development of these systems of medicine. Efforts in the fields of education, training, and practice were equally half-hearted.

Because of these developments, contrary to the prevailing "belief" among the elite classes, rural populations have lost their enthusiasm for the indigenous systems of medicine. The intensive study of the health behavior of 9 villages referred to earlier (Banerji 1973)[10] revealed that the response to major medical care problems was very much in favor of the western (allopathic) system of medicine, irrespective of social, economic, and occupational considerations. Availability of such services and ability of patients to meet the expenses were the two major constraints.

Due to this, and because of the limited capacity of the primary health centers (PHC), the indigenous systems were unable to satisfy a very substantial proportion of the demands of the villagers. This enormous unmet felt needs for medical care was the main motive force in the emergence of a large number of so-called Registered Medical Practitioners (RMPs) or "quacks". The RMPs were in effect, created as a result of the inability of the PHC dispensary or other qualified practitioners of western medicine to meet the demand for medical care services in the villages. It is worth noting that most RMPs used allopathic (western medicine) rather than Ayurvedic and Unani medicine. When these RMPs proved ineffective, depending on the economic status of the individual and the gravity of the illness, villagers actively sought help from the government and from private medical agencies in the towns and cities.

Numerous instances of adoption of healing practices from qualified or non-qualified practitioners of the different indigenous systems of medicine and homeopathy and from other non-professional healers were observed during Banerji's study. But among those who suffered from major illnesses, only a very tiny fraction preferentially adopted these practices by positively rejecting facilities of the western system of medicine. Usually these practices and home remedies were adopted (a) side-by-side with western medicine, (b) after western medicine failed to give results, (c) when western medical services were not accessible, or

(d) most frequently, when the illness were minor in nature.

Fortunately, because of the generation of internal contradictions within the ruling classes and some awakening among the masses, the political leadership in India realized that it was no longer possible to perpetuate the present social order without making some "concessions" to the masses. Health services apparently have been singled out as an area for such concessions, on the presumption that unlike sensitive areas like land reforms, minimum wage, and democratization, they would not pose a major threat to the social system.

Indeed, the rulers who assumed political power in India in March 1977 by taking advantage of the people's deep-seated resentment and revulsion against the family planning excesses of the previous months had redeemed their election pledge and initiated a new program based on village-level community health workers (Health Care Services in Rural areas 1977).'' It was a most remarkable development, though it was obvious that the existing social structure and prevailing culture of the elite-oriented professionalized health system was grossly incompatible with such a "philosophy" and that this philosophy had already been greatly distorted by these forces. Nevertheless, this commitment of the political leadership to bypass the medical establishment and go directly to the people had created a very favorable setting to challenge the basic scientific, sociological, and economic promises of the earlier approach to development of the health services in India, and formulate an alternative approach.

An Alternative Health Service System

Formulating an alternative is not the issue. The issue essentially is to offer an alternative which rectifies the distortions that have crept into the health service system because of the interplay of political, social, and economic forces. As pointed out by (Foster, 1958)[12] it is particularly important to distinguish between the true clinical care of scientific medicine and the surrounding folk magic, customs, and faddism that are included in that institution.

The same principles apply to the indigenous systems of medicine. Just as their neglect is undesirable, so is their romanticization, particularly in view of the degeneration that had set in within these systems because of political and social forces.

The central premise of an alternative health service system will be to start with the people. Instead of fitting people into a pre-determined framework, a health service system specially tailored to suit the requirements of the people must be designed. The technological elements should be designed to serve the people by ensuring that they are in consonant with the pre-existing health behavior, health institutions, and health care delivery agencies in the community; that they fit in with the social and cultural settings; and that they can be implemented with the resources that can be made available for this purpose. In other words, people should not be "educated" to discard the health measures that they have adopted unless a convincing case is made to show that, taking into account their perception of the problems and the existing resources constraint, it is possible to have an alternative technology which will yield significantly greater benefits to them in terms of the alleviation of the suffering that is caused by their health problems.

Rural Health Problems - Some Illustrations

The young mother of five children was carried into a rural dispensary, after many hours of travelling on a makeshift stretcher. Having been in labour for two days, she was unable to give birth to her twins. The personnel and facilities of the dispensary could not provide the caesarian operation that she needed. By the time she was carried into the nearest health centre both she and the twins were dead. The factors of poverty, isolation, and lack of adequate basic health facilities conspired to produce this tragedy.

Other factors which continue to characterize rural life in the tropical and sub-tropical developing areas and which have a special bearing on health include the continuing heavy reliance on agriculture and employment of manpower rather than machines, which influence nutrition, economic resources and expenditure of human energy; continuance of the extended family system; large family size and frequently crowded living conditions; the "low" status of women which still often prevents them playing a fuller role in health activities; early marriage and frequent child bearing; high illiteracy rate and low educational attendance; firmly established and conservative leadership; high incidence of alcoholism; and the existence of an intricate socio-religious system which affects the interpretation and treatment of disease.

There is often, a continuing reliance on hunting, fishing and food gathering indicating a food supply unguaranteed in quality and quantity; the introduction of processed foodstuffs such as powdered milk in infant feeding, and atrophy of the arts of food preservation. Little actual money may exist in the economy, goods being exchanged instead. Western medicaments, where available, are expensive, and crippling debts may be incurred by a family in pursuit of cure.

The major "killing" diseases in rural developing areas include pneumonia, diarrhoeal diseases, tuberculosis, parasitic diseases, infections of the newborn and measles. Then there are the so-called "silent" diseases concerning those diseases which people often prefer to be silent such as venereal diseases and leprosy. Other prevalent conditions include trachoma (in some areas more than 10% of the adults are totally blind) infective hepatitis and worm infestations which cause a great deal of debility, but which do not kill many people (Le Riche, 1967).[13] "Bilharzia" yaws and hookworm are responsible for widespread chronic disabilities and sufferings.

Infant mortality and maternal mortality are generally high; life expectancy is low; children (constituting often 20% of the population) may account for 50% of the deaths; standards of domestic sanitation and hygiene are low and there is continuing reliance on indigenous and often inadequate health practices and practitioners.

The health planners continue to attempt to grapple with rural health problems. But certain questions recur with increasing emphasis. Why, for example, do communities so often continue to receive only the fringe benefits of such efforts? Should only the health needs of those who seek treatment be catered for? What of the needs of those who do not attend the health center at all? Is the local health centre catering only to the needs of those who live near it? What responsibility should the community itself have for the provision and maintenance of its own health care? How far are health personnel being trained to regard the patient as part of his community? What are the factors within the social and political structures of a country which continually undermine health progress?

"We must not assume that health care is being cared for simply because a system of health care exists - we must learn to recognize the right issues, find out what are the right tools and put them in the right hands. It may require developing approaches to health care that are entirely new" (Bryant, 1969).[14]

There are indeed many types of community approaches currently being employed in various countries. But personnel involved in such projects are increasingly encountering the need to explore a really comprehensive approach.

Footnotes

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CHAPTER 5

WHAT IS COMMUNITY DEVELOPMENT?

The idea of community development is not new. It dates back to the early efforts of man to work together for the common good. It dates back to the times when people first came to work together to preserve their hard-earned gains and to further improve their living conditions. What is new, are the words, use to express this group process and the specific meanings ascribed to these words.

Many other terms have been used, and in some situations are still being used, to designate all or a part of this process. These include such terms as community organizations, community improvement, mass education, fundamental education, community self-help, village improvement, rural development resource development, area development and area re-development etc. These terms have different origins and different shades of meaning and emphasis, but certain characteristics seem to be common to many of them.

There are five commonly accepted characteristics of the community development process. They are as follows:

1. A philosophy, in accordance with our democratic philosophy, that local people, working in their local group situations, have not only the right but also the

responsibility to choose their own objectives and to make their own decisions.

2. A concern for changing the local situation with a view to improving conditions in the so-called community. This implies, of course, influencing people's value systems, assuming that both individual and group values can be changed.
3. A belief that lasting progress can be achieved only through the development of local understanding, local initiative, and local self-help, with a broad local participation as possible. This emphasis points to the importance of education.
4. An emphasis on the balanced development of all the resources, physical and human at the community level. It is basically a matter of organization, with a concern for the development of the total community.
5. An assumption that outside resources, including council and technical assistance, are available to local community situations, both public and private sources.

Definitions Of Community Development

Since community development came to be recognised as an effective and powerful method, capable of being consciously applied, for promoting rural improvement in less developed countries, many attempts have been made to define community development. The 1948 Cambridge Conference defined community development as:

> A movement designed to promote better living for

> the whole community, with the active participation and if possible on the initiative of the community, but if this initiative is not forthcoming spontaneously, then by the use of techniques for arousing and stimulating it in order to secure its active and enthusiastic response to the movement.[1]

The United Nations have adopted the following definitions:

> The process by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation and to enable them to contribute fully to national progress.[2]

Lakshmir Bharadwaj, who made a careful study of the concept of community development from the international point of view, stresses the importance of social action. He suggests the following "workable definition" of community development:

> process of social action by which voluntary efforts of the people are combined with those of government toward an overall improvement in conditions of community living within an accepted national pattern of social and economic progress.[3]

Irwin Sanders has pointed out that the term "community development" even in its education-action sense, can and does have different meanings to different people. He suggests that people may view it as a process, a method, a program, or a movement.

Community development has been described as a '*process* of change from the traditional way of living of rural communities to progressive ways of living; as a *method* by which people can be assisted to develop themselves on their own capacity and resources; as a *program* for accomplishing certain activities in fields concerning the welfare of the rural people; and as a *movement* for progress with a certain ideological content.[4]

In these definitions are to be found the different elements that constitute the concept of community development. The objective is promotion of the all-round development of the communities - economic, political, social and cultural. When looked upon as a process, the emphasis is on the change that takes place in the people socially and psychologically; when viewed as a method, the emphasis is on the ends to be achieved; when viewed as a program, the emphasis is on the activities in specific matters, such as, health, education, agriculture, and when viewed as a movement, the emphasis is on the emotional content or ideology behind the program. But for a full understanding of community development, it is essential that community development be viewed as a whole, as a process of change with clearly conceived objectives; as having its own special method or way of working, applying these to promote activities that may need to be taken up in any program of rural development; and finally as a program capable of being developed into a movement with an emotional and ideological appeal.

The two essential elements in community development are 'participation by the people themselves in efforts to improve their level of living with as much reliance as possible on their own initiative; and the provision of technical and other services in ways which encourage initiative, self-help and mutual help.

The Evolution Of India's Community Development Program

During his struggle for independence, Gandhiji had realised that political freedom alone would not be of advantage unless the rural masses felt that they could improve their lot by their own efforts and could shape their destiny the way they like. His constructive program, therefore, covered Khadi and other village industries, basic and adult education, removal of untouchability, rural sanitation and health. When Gandhiji had developed a rural reconstruction project at Sevagram (Wardha), his contemporary, Rabindranath Tagore, was convinced as a humanist that real freedom of the soil and the body could only come when people were independent of fear and hunger. His experiment in rural reconstruction at Sriniketan (West Bengal) aimed at making villagers self-reliant and self-respectful. At this time, another extremity of the India-Spenser Hatch of Y.M.C.A. was doing work at Marthandam in South India. As a true Christian, he dedicated himself "in the service of God through service of man".[5]

Sir V.T. Krishnamchari, the Prime Minister of the princely state of Baroda was the live-wire behind the Baroda rural development program. The Gwagaon experiment under F.L. Brayne (Deputy Commissioner under the British Government in India) emphasised agricultural development, sanitation, education and co-operation. While Gandhiji propagated Sarvodya, non-violence, dignity of labour, the Village Development Scheme of Madras made quite a headway in attaining the Gandhian ideal of Village Swaraj.

After Independence

After independence, pilot projects of community development at Etawah (U.P.) and Nilokheri and Faridabad (Haryana) provided valuable lessons to design the National Community Development programms in 1951. The recommendations of the Grow More Food Enquiry Committee were responsible to a large extent in shaping the extension approach which became an essential vehicle of the Community Development program in India. It was felt that the central idea of the program was investment in man through the means of integrated extension service and scientific knowledge and techniques. The First Five Year Plan gave recognition to this approach in the following words:

> "Community Development is the method and rural extension, the agency through which the Five Year Plan seeks to initiate a process of transformation of the social and economic life of the villages".[6]

The India-U.S. Technical Co-operation in 1952 enabled a beginning to be made in intensive development of rural India. Thus the community Development was ushered in as part of India's development planning.

An Evaluation Of The Community Development Programs In India

Despite the fact that the Community Development Program in India was commenced with great zeal and enthusiasm, there were no sustained attempts to involve the local people. Neither was their participation in the development process given due recognition. Consequently, India's community development program fell short to meet the "felt needs" of the rural population.

The purpose of encouraging the people's involvement, it was mooted, was to have a democratically elected body of villagers at the village level. This body was called the Panchayat, and it was charged with the task of involving the people in the task of development. Each Panchayat was given a village level worker, who had to function as a multipurpose catalyst and as an extension agent.

The Involvement Of The People

The Panchayats, for administrative purposes, were grouped into blocks each covering 60,000 to 70,000 people. In turn, 15 to 20 blocks constituted a district. At the village level, there were various institutions sponsored by the Panchayats in order to involve people. A co-operative society was established to carry out the economic and commercial functions. To encourage youth development and to encourage the women to participate, the "Yuvak Mandals" and the Mahila Mandals were formed respectively.

A rural works program was launched with the idea of evoking the participation of the people on a self-help basis aimed at their advancement as well as to the advancement of the nation.

The Panchayat was established with the idea of bringing about the involvement and participation of the people. In the words of Nehru:

> "The people were too invested with a sense of intimate partnership" (Dube, 1958).[7]

According to the First Five Year Plan, the aim of the C.D. movement was to create in the rural population, a burning desire for a higher standard of living and the will to live better. (Five Year Plan 1958).[8] For such an aim to be achieved not only would the participation of the people be a definite requirement, but the educational role within their participation would have to be utilized to the maximum. But unfortunately, this was one of the failures of the Panchayats. In the words of Henry Maddick:

> "Admittedly one of the least successful aspects of the community projects and National Extension Service work is its attempt to evoke popular initiative" (Maddick, 1970).[9]

Although in theory, there should be participation of the people, in actual practice, real participation did not take place. In a study of Rajasthan, P.K. Chaudhuri says that there had been very little involvement or participation on the part of the people in the preparations of plans for community development. He says:

> "the so called village production plans that we have today are nothing but paper plans casually prepared by village level workers, in consultation with a couple of village elders and the village Panchayats members. No serious attempt has yet been made to prepare an authentic village production plan" (Chaudhuri, 1964).[10]

In many instances, the people failed to participate. They had not been sufficiently motivated and they failed to understand or appreciate the value. Kusum Nair points out at a meeting in Bishenpur, where out a of total of 4,000 people only a bare 15 had been present (Kusum Nair).[11]

Contributions By The People

In the C.D. programs in India, the people's involvement was normally gauged in terms of their contribution. This was a misnomer, as people's contribution is not the same as people's involvement. What really happened was that when the rural works program was commenced with the people's support, the people contributed labour. In the ca[illegible] of rich people, the contribution was in money or in kind. What should have been done, was to involve the individuals who contributed in labour or in kind, in the development process, to enable them to decide the tasks and goals and then to work in collaboration with each other in achieving such tasks. The importance lies in "the process by which the community identifies its needs or objectives, develops the will to work at the needs or objectives, finds the resources to deal with these needs or objectives, takes action to get them done, and in doing so develops cooperative or collaborative attitudes and practices in the community" (Mukherjee, 1961).[12]

However, the involvement of the people did not take place. Instead the emphasis was on the task of obtaining the contribution in labour and kind, depending on the wealth of the donor, and on attending to the tasks.

This deficiency was soon realised. However, no effective corrective action appears to have been taken to correct the situation. Mukherjee quotes:

> "People's participation should not be regarded merely as providing a certain portion of a particular work in cash, or in a kind of manual labour, but it is their full realisation that all aspects of community life are their concern and that Government's participation is only to assist them when such assistance is necessary" (Mukherjee, 1961).[13]

A survey conducted on the participation of the people in the Shramadan projects, established that "55.3% of the surveyed households had participated in the development activities of blocks and 44.7% had remained in the dark but as Dr. P.D. Maheshwari adds this participation was one of contributing one's labour or money.

> "Generally people's participation was in the form of Shramadan for construction of approach roads, construction and repair of drinking water wells, construction of school and dispensary building, etc." (Maheshwari, 1970).[14]

The contribution of voluntary labour by 55% of the people was to be admired. It was a situation on which real self-reliance could have been built upon.

In the Punjab, a study made by B.S. Khanna reveals that "the system has not sufficiently stimulated popular participation in the execution of development programs. A large portion of the people had not made any contribution towards these programs and others did so on a very restricted scale (Khanna, 1969).[15]

The Rural Works Program

The undue emphasis placed on the construction of rural works gave the people a different picture of the concept of C.D. Carl C. Taylor tells of the replies he received to the enquiries he made in 1958 from 13 important people regarding what, in their opinion, had befallen the C.D. movement in India. The reply he received was that instead of a community development extension program,

> "the program had become a construction program and an amenities program and finally an administrator's program" (Kurukshetra 1966).[16]

The rural works program, instead of being built-up to be a development-oriented program where the people's abilities and skills were developed and a sense of community awareness leading to self-reliance was encouraged, actually dwindled to a "bricks and mortar" program without any degree of education or learning by the participants.

Kusum Nair refers to the replies she received from the people who were contributing their labour for the construction of a community centre at Dosma in Bihar. In her words,

> "It is an impressive building, big and solidly made of brick, coming up rapidly at the entrance to the village. It cannot be missed. The walls are already up".

The amount of human toil and effort that had gone into its construction would have been enormous, but to her question as to what they were making,

> "They looked at each other in consternation. It seems none knows. Then one of them says they are going to have a hall?

To her repeated question as to why they were making it,

> "No one knows. They are all confused by now. One of them picks up courage to say that he helped because the malkin (master) had said it should be made, but

> I do not know why?"

Then another man says,

> "It is being made for the hakims (Government officals) to sit in. Since they have started coming to the village they need a Katcheri (law court, office) to hold meeting in. That seems to be the most plausible reason and it is readily endorsed by the rest." (Kusum Nair, 1961).''

It is evident that the people had been compelled to contribute labour. This is not true participation and has no educative value. How the people's initiative should have been actually harnessed in these development tasks is shown in the following words of R.N. Haldipur, Dean at the National Institute of C.D., Hyderabad:

> "It was visualised that certain activities in the field of planning and development could be undertaken and achieved through people's participation. It was assumed that people would develop a sense of "enlightened self-interest", take decisions, implement them and maintain self-help programs for the larger common good, including that of the weaker sections of society. Initially the people's contribution was considerable, both in kind and money, but it wore off, as more and more was expected from a rural society, which was neither economically viable nor socially cohesive." (Haldipur, 1971).''

The contribution initially obtained from the people had to inevitably dwindle away as it was not an educational awakening for the people. It was toil, a pure labour contribution, the people themselves not understanding why they were doing so and not being involved in decision making.

Huge Tinker in his "Authority and community in village India" stresses that the idea of public participation got progressively sidetracked.

> "And so the officials make the decisions, for the good of the people, of course, but without their active participation. Instead of C.D. being built up of rural needs, it is dispensed from above, often concentrated into a few major projects, which are easier to plan and administer and yield concrete results . . . . . the original intention of development, whereby the administrator's role will be to "prime the pump", to ensure that the venture was fairly launched and transfer authority to the people, has been disappointed. In many areas where the impluse from above has weakened the people's contribution has dwindled away". (Tinker, 1960).''

If the people were to be made self-reliant and their initiative awakened, they had to be encouraged to participate in the cooperative action, that goes into any work process. Once this is side tracked, the program cannot be a success.

Neglect Of Non-Contributing Areas.

Another cause for the very low participation and involvement of the people was the administrative management, whereby the Government did not undertake work in any areas where the people could not contribute on their own. This meant that no work was done at all in the poorest villages, where the motivation was least and where the people really required a change in attitude. Dr. Ram Vepa says:

> It has also been noticed that people's participation has tended to differentiate the well-to-do from the poorer classes. Where a community is fairly prosperous, it has been able to come forward with the necessary quantum of participation in terms of money (usually from one or two such individuals), and the entire community had therefore benefitted. In respect of poorer communities, where in fact the need is greater, the work is not taken up since the quantum of participation is not forthcoming. Although it was indicated that this could be in the form of labour, it is futile to expect that people on the verge of starvation would have enough energy to provide free labour for a work which would benefit not themselves alone, but their entire community." (Vepa, 1966).[28]

Making the people's contribution compulsory was a definite criterion to ensure that the people co-operated. However, it did not mean the real involvement of the people.

Leaving out the poorest villages meant that there could be no advancement at all for those people. The solution should have been to find some task of a felt-need type, however small, which would have aroused the enthusiasm of the people, motivated them and made them work together. Instead, leaving out the poorest villages discredited the C.D. movement. This attitude cut off the participation of certain major sections of the population that required perhaps the greatest attention in motivation.

What Section Of The Village Participated

Even within the limited achievements secured through the working of the Panchayats, the masses of the people had been generally ignored. There was no rural awakening or public enthusiasm created to endure or to educate the people to participate and so it happened that the traditional village leadership crept into the Panchayats at the elections. Thus, although one could assume that when the Panchayat functioned, the participation of the people was assured, the real situation was that the bulk of the people were left alone, while a few leaders and upstarts who found their way to the Panchayats ran the show.

The editorial of Kurukshetra of December 1969, refers to a paper prepared by the National Institute of C.D. It says:

> "What is the influence exerted by caste and wealth in the running of the Panchayats? According to the

> paper the Panchayati Raj leadership is in the hands of the rich and the higher classes" (Kurukshetra, 1969).[21]

A sample survey conducted in 1964 by the Indian Institute of Public Opinion in the nine states of Andhra, Gujarat, Madras, Maharashtra, Mysore, Orissa, Panjab, Rajasthan and Uttar Pradesh, revealed that:

> "the overwhelming majority of the elected leaders of Panchayati Raj were cultivators, most of them (80%) being owner cultivators and only a negligible percentage (3%) belonged to the non-owner cultivator class" (Bhattacharya, 1970).[22]

Myrdal quotes a report of the Government of India to the effect that the weakest sections of the village received the least benefit.

> "As one official report in India stresses, as long as the present pattern of society and habits of thought remain, the fruits of development are bound to be most unevenly distributed, the weaker sections receiving the smallest portions." (Myrdal, 1970).[23]

It is quite evident that in the actual working of the C.D. Program in India, the weaker and poorer sections had been completely left alone. It is actually in their motivation and their active participation that the true test of a C.D. program lies.

The Functioning Of The Panchayats And Gram Sabha

The Panchayat was created, based on adult suffrage, to enable the people to participate. The mere fact that the elections of the Panchayats took place, in no way implies the total participation of the people. The people's participation could however be established in two ways, firstly, in the functioning of the Gram Sabha, the village body of adults, and secondly, in the opinion the people held of the Panchayat and the C.D. movement as a whole.

According to law, the Gram Sabha, the General body of the Panchayat had to be convened twice a year. This guidance by legislation was only to ensure that the Panchayats did not completely work on their own, ignoring the people. In fact, if the people's participation is to be fully evoked for development and the people are to be truly involved in the development process, meetings of the Gram Sabha would have to be held quite frequently, because this is the one body in the working of which, ample opportunities would be created by the appointment of committees, responsible for the studying of reports, discussion and deliberation of plans and problems of implementation. This would enable the participants to go through an educational process within the development program.

The important role that the Gram Sabha should play, in the words of S.K. Dey:

> "The village Panchayat can be a menace to itself without a continuing check from the people. There must be a wider institution of the people for which

> the Panchayat can be the Cabinet. This institution has not been recognised to be the Gram Sabha. The Gram Sabha should elect out of itself the Panchayat . . . . . . They should review the work of the Panchayat". (Dey, 1961).''

The Opinion Of The People

The people had not been encouraged to participate educationally within the development process, and consequently, the people could not have a correct picture of the function of the Panchayat or the C.D. Movement. Henry Maddick quotes the remark made by the Minister for Local Self-Government from Assam, at the meeting of the Central Council of Local Self-Government Ministers in 1957:

> "Block Boards, National Extension Service Blocks, have not been able, to my mind and also to that of my colleagues who express the same opinion, to enthuse the people. The ordinary villager thinks that it is some organization imposed by the Government, and therefore very little development work has been done by these N.E.S. Blocks (Maddick, 1970).'' A survey conducted of the people's reaction to village Panchayats in the Khanjawala Block in Delhi also reveals the fact that the people had a poor opinion of the Panchayats:
>
> "As far as 90% of the people interviewed,

> held the opinion that the Panchayats had created functions and aggravated conflicts". (Singh, 1971).[16]

The Actual Functioning Of The Panchayats

Another criterion depicting the incidence of the participation of the people is the actual functioning of the Panchayats. Henry Maddick quotes the report of A.V. Raman Rao, regarding the working of Panchayats in Bombay and Madras.

> "the attendance of members at rural meetings was so irregular that there was often no quorum. Sometimes the Panchayats had no meetings at all for a long time, or members absented themselves continuously without any action being taken against them". (Maddick, 1970).[17]

Agricultural Development

At its inception, the C.D. movement in India was welfare-oriented, and agricultural development was not emphasized. However, as agricultural pursuits happened to be the main livelihood of the people, and any development in this field would automatically bring about rural upliftment and an increase in the income of the vast majority of families, agricultural development became the main concern of the C.D. movement. The Intensified Agricultural Development Program of 1960 was a further step in this direction.

The task that had to be surmounted in agricultural development was immense, due to the excessive population dependent on agriculture, the existing pattern of subsistence agriculture and the land tenure system. Kusum Nair says:

> "Each of India's millions of agricultural holdings is an autonomous unit of production and must remain so. Production in agriculture, will therefore continue to be the ultimate and individual responsibility of over 70 million peasants . . . . . Unless the desire for change and for appreciably higher living standards takes root in the peasant communities, these techniques will often not be accepted or exploited fully, as has been the case of the Japanese method of paddy cultivation, for example. This technique was introduced in the paddy growing areas about a decade ago. But rarely has it been adopted in its entirety anywhere. The average yield of rice at 906 lbs per acre (1960-61) continues to be the

lowest in the world". (Kusum Nair, 1961).''

Even though a change in attitudes was emphasized at the outset, this was never achieved. Consequently the farmers functioned as mere cogs in a wheel, and never graduated from their subsistence level of farming. This lack of education and the consequent lack of any positive and dynamic attitude on the part of the farmers, had really caused the failure of agriculture in India.

Role Of Education

If the people are to be made self-reliant, their education has to be emphasized within the development process. For development programs to be a success, there has to be a definite change in the way people think. The people have to be motivated and must function dynamically in the development process, which would lead them to be self-reliant.

> "The requirement for economic growth is for the citizen of a developing country to acquire the ability to concert their individual behaviours into a national network of increasingly large scale specialized units of collective action which are necessary for development and widespread use of increasingly productive technologies". (Brewster, 1967).''

This situation had to be corrected by concentrating on the education of the people. It would be futile to wait till the people are educated. The people have to go through and experience learning situations in their developmental tasks and these would cause an awakening in them. It was for this purpose that social education officers were appointed and education concentrated on at the outset.

Social Education

> "the most important part of the program of social education is to enthuse the rural population and to secure their participation in all the development programs under the C.D. Projects, such as health, sanitation, communication, village industries, agriculture and other aspects of general village improvement. Other activities organized are literacy, health education, education in citizenship and a program of follow-up activities with a view to prevent re-lapse into illiteracy and ignorance. . . . . . . in order to start the process of group formation, programs of youth welfare and child welfare are taken up and physical welfare activities such as games and sports

are planned". (Dayal, 1960).''

With these tasks in view, social education officers were posted to the Block level. They were entrusted with the entire task of creating a community spirit within the people and obtaining their participation for the development programs.

Adult Education classes were concentrated upon within the Social Education Program. These were pure literacy classes, with the aim of teaching adults the art of reading and writing. There was no connection between the life the adults led or the occupations in which they were preoccupied on the one hand, and the content of the literacy classes on the other. The concept of functional literacy had not gathered momentum and it was thought that the mere acquisition of the skill to read and write would aid in furthering development programs.

Adult literacy classes were held all over India, under the C.D. program. These literacy classes gradually become very unpopular among the people, as the content had no connection with their life or their vocational pursuits. As the people who acquired the ability to read and write, had no occassion to continuously use them in the development program or in their day to day life, they lapsed back into their original illiterate stage.

> "In India, even those who have had a year or two of schooling lapse into illiteracy for want of follow-up literacy work. In certain areas, the lapse is as high as 60% within one year". (Lakshmi Menon, 1970).''

Community Development - A Strategy

In India, the concept of community development got confused by particular task oriented Ministers. If community development had been introduced as a strategy to be utilized to make the program effective, this concept would never have got lost within a "bricks and motar" program of rural works or an intensified agricultural development program. Instead of C.D. retaining its character as a strategy, it became, "Yet another agency for spoonfeeding the people; instead of being the focal point of people's efforts to work for their own welfare and programs. It is thus inevitable that the C.D. program, instead of making the people self-reliant, has made them increasingly dependent on official assistance". (Dwivedy, 1965).'' According to Mukherjee, the C.D. Program became entirely task oriented and hence the educational process orientation got completely sidetracked.

"Looking back over the period, I get the

> impression that as workers in the program, we realized inadequately that the weakness lay in the method followed in determining the program objectives, priorities and targets and in implementing the programs. The bulk of the thinking done in conferences and seminars during this period was devoted to problems of implementation of the program of activities, reasons for failure to achieve the targets of physical accomplishment and to failures of the administrative machinery to get things done and achieved by the people. Not enough thought was devoted to the process of community development and to relating the program activities to the community development objectives." (Mukherjee, 1961).[13]

John W. Mellor after a study of the causes for the failure of the C.D. program in India says:

> "It is easy to argue the failure of the community development program, but it is difficult to formulate a better alternative for the India of 1951." (Mellor, 1968).[14]

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CHAPTER 6

COMMUNITY DEVELOPMENT AND PRIMARY HEALTH CARE

The term "community development" is not always understood by those engaged in rural health activities. Community development is a specific approach, a pattern of well established practices emanating from certain principles, attitudes and objectives. And, although often in operation in close proximity to rural health activities, health personnel are frequently unfamiliar with its implications.

In 1954 the World Health Organization Report on Health Education (TRS 89)[1] did not emphasize the need for any special knowledge of the community development approach. However, by 1958 a further report in the series (TRS 156)[2] pointed out that training in health education should be made available to workers in other fields including community development and that health workers had the responsibility to assist with community development programs. Thus in four years community development had not only been recognised, but special training in this field was felt to be an essential part of the training of all health workers.

In some developing countries, the community development approach has, in fact, been used in rural health improvement activities, as for example, in the well and latrine construction projects. But it has not been used extensively and never in its most comprehensive sense. Rather, a few techniques have been "borrowed" in order to achieve certain health objectives. There is evidence to suggest that today where community development does form a part of rural health activities, it is usually regarded as being distinct from them and slightly oblique to the health activities.

> "There are far too many examples of social indifference and even arrogance on the part of the health professionals towards the consumers . . . . this is one of the root causes of the under. . . . or improper utilization of health services . . . . It is most important that the consumer's social perferences, needs, interests, aspirations, goals and values should be identified . . . . and that these aspects are allocated a carefully considered and reasonable weight in the planning and implementation of health care . . . ."[3]

In Nigeria a cholera prevention program attempted to influence the members of one rural community individually - in the traditional manner, while in another it aimed at securing community approval. It was subsequently found that in the first community 45% of the population reported for vaccination, while in the latter, 73% of the community responded.[4]

> Controversy continues today as to which particular "community" approach is the most feasible,

preferable or desirable.

> At a sympsium in 1970 Professor Maurice King enjoined health personnel to "peer over the top of the accepted and look round the edges of the conventional . . . . our predecessors used this microscope well; our challenge is to use the instruments of our time with equal determination and with equal vision."[9]

While many health personnel are by no means reluctant to consider "peering over the top of the accepted" in the search for new and more effective approaches to the problems of rural health, the very magnitude and complexity of those problems appears to weigh the scales heavily against them.

Community-Based Health Care Programs

What is a community based health care program? As the name implies, it involves a community and its focus of attention is health. Involvement of the community here, does not mean a passive involvement where the people become mere recipients of the services which the program offers, but rather the involvement of the community in all aspects and stages of the program.

If it involves a community, it thereby involves people. The primary and ultimate wealth of the community are its people. A community-based health care program therefore, gives importance to people. It is people-oriented.

Some elements of a community-based health care program which have been recognized and described include the following:

1. the community knows, feels and accepts responsibility for community health and not just the health of the individual.
2. the community taps and develops its own resources to meet health needs; this includes personnel and material resources, professional and traditional persons. This also includes private and government endeavours, institutions and organizations, local, provincial and national.
3. the primary focus is put by the community on community problems, community resources and action, according to community priorities.

Whereas before, health care was centered only in taking care of the individual sick patient; it was then expected to include the family; now the trend is the health, the well-being and the future of the whole community.

The approach herein is termed holistic. In any community, community-based health care programs are inter-related with the economic, the political, the social and the cultural problems of society. Health from this perspective is viewed as only one component of the overall development of the community. Rather than laying emphasis on the acquisition of high quality and sophisticated medical skills and treatment for the community, priority is placed on using health as a way to motivate people to improve their standard of living and their quality of life. The people start to see that their health problems are related to food production, nutrition, water supply, housing conditions, education, income and its distribution, unemployment, communication and transport and ultimately to political decisions. Physical health then becomes not the main concern; the mental and the social health of the people are given due recognition. The total well-being of man and his community is taken care of. The long-range welfare of the community is thus considered. The program helps the community to stand on its own feet. It genuinely encourages responsibility, initiative, primary decision-making and self-reliance at the community level. "It is built upon human dignity."

Community-based health program are to be differentiated from community-oriented health care programs which are essentially hospital-based and doctor-administered. These programs rely on community participation mainly to provide information by which the medical professionals can modify their services. Activities and decisions are dominated extensively by the health professionals and by the staff.

There is a usual pattern in these community-oriented health programs. The staff members of the program start off with a survey of the community where the program will be established. The survey normally includes population data, disease patterns, environmental sanitation problems and some basic socio-economic information. When the results are collected and analysed, the staff then identifies the cause of the main health problems of the community. On the basis of this analysis, the staff sets the goals and objectives for the community and initiates a course of action to activate the goals and objectives. Plans include both curative and preventive services plus the utilization of other health and health related agencies working in the locality. The staff then goes to the community leaders and try to find out ways in which the leaders can help implement the plans that the staff has made.'

Such community-oriented health programs perpetuate a paternalistic attitude even though it utilizes aspects of community-input, it actually encourages greater dependency, servility and unquestioning acceptance of outside regulations and bureaucratic decisions.

In a community-based health care programs, the initial goals, objectives and planning are open ended and flexible. It considers the community's felt needs and not the needs as felt by the health professionals. The program staff only inspire, advice, motivate and demonstrate but do not make unilateral decisions. The community is strongly involved in all areas where decision making is needed. Community-based health care programs are, therefore, built from the grassroots up and not given from the bureaucrats or institutions down to the people.

Any program directed towards the community will not work without the primordial element of community awareness and community involvement in the planning and implementation of such a program. It must involve those who suffer from disease and poverty and it must let them take the decisions and responsibility for their own health care. Unless and until the people in the community comprehend what it is all about, programs imposed upon them or taken to them without adequate prior preparation will not succeed. They may work for a time, but they will not endure.'

In community-based health care programs, the basic attitude in working with the community and giving to the community, is to improve health. Finally, community-based health care is "health by the people" rather than "health to the people".

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CHAPTER 7

THE COMPREHENSIVE COMMUNITY APPROACH TO THE RURAL HEALTH PROBLEMS IN DEVELOPING COUNTRIES

This approach is one by which individuals and communities are helped to perceive, within the context of the national health plan, their health needs, (that is the need to change beliefs and/or behaviour in order to increase the incidence of good health) and are aided to remedy their health conditions by the utilization of internal and external resources. The long term aim is improved rural health conditions and services, the responsibility for whose organization and maintenance rests largely with the rural communities themselves.

An Holistic Approach

Historically, many rural health activities have occurred independently of planned national development or, more specifically, of the National health plan. Practitioners of traditional medicine, for example, have had a more co-ordinated relationship with the National health care plan, they have generally functioned independently. And until recently the activities of philanthropic and religious organizations which established hospitals and dispansaries in rural areas have had little co-ordination with the national health plan. Health activities took place in isolation from the nationally planned ones. Overlap, duplication and conflict have resulted in such cases where there has been no coordinating policy. An agricultural rural development agency, for example engaged in stimulating increased egg production for cash return, found itself in direct conflict with a nutrition program in the same area which was encouraging the increased production of eggs - for home consumption.

Without co-ordination, on the one hand, activities are persued which are unrelated to nationally selected priorities, and on the other hand, national health planners are often unaware of all the resources available for rural health activities.

Today, co-ordinating bodies do exist in some countries. Co-ordination itself is far from easy. The health activities of religious organizations, for example, have emphasised, curative rather than preventive or educative care, both of which may be priorities of the national health plan. To add to such conflicts, a vital question remains unresolved, that is, how far is effective liaison really possible between religiously oriented bodies who are in competition on the theological level?

However, there are many examples of co-operation such as the missionary doctors of Zambia who have played a significant role in training medical auxiliaries.

A comprehensive community approach is a holistic one, and the process of its adoption is rendered more difficult because of the "fragmented" nature of the present rural health care programs in India.

Long-Term Community Objectives

Long term community objectives include the evolution of the rural population into healthy citizens, capable of fully participating in their own lives, in that of their communities and nation, and assuming wherever possible a greater share of responsibility for the delivery and maintenance of rural health activities.

The objectives of the health personnel are often far from clear to rural communities, and this has resulted on occasion in resentment and conflict. A south American study revealed that a community found its health centre staff lacking in tact and good manners: the staff considered themselves as being of a higher socio-economic group and therefore "superior" to the rural population. For the community, long periods of waiting preceded attention, and most seriously, the centre did not treat sick children. (The centre saw its role as preventive and was not fully equipped for curative treatment). To the community, prevention was unnecessary, one only needed treatment when something went wrong. What they desired was treatment for their children. They felt their primary desires were being disregarded so there was little confidence in and co-operation with the centre.

In the South Pacific, an assessment of a latrine building program concluded that too often "latrines were built only to satisfy the desire of administrative personnel, and unused they stood there, mute symbols of the willingness of people to cooperate" (Mahoney, 1957).[1] The community's objectives then did not include the acquisition of latrines.

Only a good communications system can ensure that health policy-makers are really familiar with the objectives of rural communities, and vice versa. When national resources are limited, it is important for communities to understand the reasons for decisions about their allocation. And local health personnel may have little idea as to the overall national policies and therefore become easily frustrated by seemingly inexplicable plans, shortages and objectives. Communities also need to be aware of the problems of the health personnel. One of the Indian rural health project the communities were asked to listen to the physician's problems. Lack of roads was a constant hindrance. Eventually the villagers constructed a 7 mile road themselves and a local Ministry of Health paved a further 50 miles of road (Maidan, 1973).[2]

A criticism, levelled at previous health activities, is that long-term objectives have often been obscure, if not totally lacking. Statistical evidence of a large scale vaccination scheme has very often been regarded as a hallmark of "success", with little attention given as to whether deep-rooted popular attitudes and beliefs have been changed or "merely" disrupted.

An Integrated Community Approach

In India, each state has evolved a specific pattern of health development, consistent with its own tradition, circumstances and aspirations. Special emphasis is placed on the concepts of integrated development, appropriate technology and the employment of new categories of health personnel.

India's annual per capita expenditure to provide health care for its 720 million people is under one American dollar, one hospital bed for 1000 of the population, and one doctor and nurse for from 1000-28000 people (Bryant, 1969).[3]

Curative care continues to be allotted the largest "slice" of available resources, and 80-90% of the total health budget is spent in services in the larger population centres where only 10-20% of the population live.

In rural areas who is it that receives the care that is available? In many instances, a "cafeteria" approach has evolved where it is "first come, first served". Those who do not come, or are unable to come receive no care. But there is also the danger of spreading health resources so thinly, that they become ineffectual.

Large hospitals traditionally absorbed large resources, but smaller hospitals and health centres are now being increasingly employed. "Auxiliary-staffed health centers represent a substantial return in human welfare for comparatively little expenditure of money and skill". (King, 1966).[4]

In the past there have been specialized divisions in rural development, each pursuing particular problems such as education, agriculture, or a specific disease eradication target, and each with its own program, personnel and resources. Co-ordination has been the exception rather than the rule. This "fragmentation" has on occasion detracted from the overall success of such activities. Rural communities, not regarding their own lives as compartmentalized, have been bemused by the influx of various agencies, each concerned with just one compartment of their lives.

There is a pressing need to view health problems in their totality. Health is a social as much as a medical problem. If, for example, the problem identified is infantile malnutrition, then more than just improved nutrition classes are needed, for the problem also embraces socio-economic conditions, education, domestic hygiene, agriculture and food technology. For the realistic confrontation of this problem, then, an integrated viewpoint is necessary. The aim, for example, of the "Jamkhed project" was a "complete integration of curative, preventive and promotional work, so that there was no category such as a public health nurse or any other worker in one specialized field alone. In a small rural health clinic, it is important that each professional knows more than his own skill."[5]

A central problem in the provision of basic health care concerns the changing role of the health personnel. For example, "the physician must fill a role in which he manages limited resources to meet the comprehensive health needs of large numbers of people, rather than serving as a personal physician for a few." (Bryant, 1969).[6]

A further problem is the frequent reluctance of the health personnel to work in rural areas. In a central American country, trained health personnel from urban areas, according to the co-ordinator of a rural health project, are "not only reluctant to work in the isolated, culturally distinct (project area); they actually refuse to work there. In some government agencies it is regarded as a punishment when one is assigned to this area." (Personal Communication 1973).[7]

Rural areas also tend to lack the socio-cultural and educational opportunities to which the personnel and their families are accustomed. Again, a lack of health facilities often hampers a high standard of health care.

Even where a part of medical education occurs in rural areas or where postgraduate rural service is compulsory, these measures are unlikely to provide the long-term answers to the problem.

The role of the nurse continues largely to be associated with hospitals and health centres. The nurse from and in the community is a relatively new concept. "The nurse has a contribution to make to the total concept of health care that goes beyond clinical activity and techniques, to encompass such things as education . . . . . nutrition and other elements that ultimately affect the health of people" (Hussalem, 1973).[8] The role of the nurse, however, varies according to circumstances. In Malawi for example an auxiliary nurse will often run a rural dispensary alone. "To many patients, auxiliaries mean more than doctors, they work long hours in lonely places". (King, 1966).[9]

Auxiliaries are increasingly being regarded not as "stop-gap" measures until more highly trained personnel become available, but more as a new category of workers in their own right. One of India's rural health project "Jamkhed" auxiliary-organized community care was planned in the villages in the form of under-five clinics, ante-natal care, immunization programs, detection of chronic illness such as TB or leprosy, school health programs, basic sanitation and family planning. Indigenous practitioners, teachers and other leaders aided them (Arole, 1972).[10]

A survey in 1971 of a Ghanian rural health project revealed, that almost all diseases encountered were readily diagnosed and treated by auxiliaries using relatively few drugs. Problems surround their role and status, remuneration, availability of further training opportunities and supervision. (Professionals are seldom trained for this supervisory role).

The use of auxiliaries is increasingly seen as not only holding a possible key to the problem of personnel shortage but also to the total effectiveness of rural health care delivery.

Community Culture

An appreciation of the socio-cultural context in which health activities occur should be considered essential.

"The success or failure of a medical program depends on many cultural factors besides competence of doctors and quality of services". (Lewis, 1969).'' Lack of a cultural understanding has robbed many health activities of their effectiveness.

In rural India for example, a well and latrine building program was initiated. The wells were successful. But the unused latrines fell into dis-repair. It transpired that in order to properly flush the latrine at least a quart of water was required after each use. So, the larger the family the more intolerable had been the water-carrying burden on the women. In Ghana on the other hand, the pouring of "Libation" drinks and water on the ground (the traditionally prescribed ceremonial) marked the inaguration of the Danfa rural health project, and initiated the health activities in a fashion comprehensive to the community.

It has been asserted that medicine often work effectively, despite the total ignorance of a patient's culture. While this may often indeed be true, it is yet a narrow point of view. For example, even if a child is cured of malnutrition, recurrence is almost inevitable and treatment most likely to be poured into a vaccum with limited effectiveness, unless his socio-cultural and economic background is effectively considered.

Health personnel are increasingly enjoined to become aware of the health beliefs and practices of a community, the reasons for their existence, how customs are linked to one another and how new health habits often cannot be introduced by merely "adding" them to a pre-existing sequence or old habits merely "subtracted".

Culture must be understood in its relation to health. For example when children are malnourished, why will a community not use the readily available protein source of eggs? Why is there a prohibition on eating eggs? These and similar questions can only be answered with a knowledge of the context in which they occur. There is an appreciation of the fact that communities have distinct, valued and time-tested beliefs and practices related to health and disease.

Some years ago, a revolutionary new method for the rapid healing of fractured bones was found to be the very same technique as one that had been used for centuries by certain south Pacific Islanders. And in Africa, long before the advent of modern vaccination, people had been rendered immune from smallpox by vaccination with the seab exudate from mildly infected persons.

Some systems of indigenous medicine are well developed such as those of China, where the system is practised concurrently, and also synthesized with, western medicine, and the Indian Ayurvedic system which is practised along-side Western medicine.

One of the most significant contributions that indigenous medicine has made to mankind is knowledge of the natural remedies such as opium, cocaine and eucalyptus, and "mind-influencing" medicines which were used centuries before the development of modern psycho-therapeutics.

After a study of Mexican Indian, Margaret Clark concluded that "the causes of illness and mortality and curative procedures are understandable and logical in the light of (indigenous) beliefs . . . . . only to be understood in terms of the total culture" (Clark, 1970).[12]

In indigenous medicine, the patient's physical, psychological and spiritual needs are considered in toto. Health care is rendered within the context of the family, who represent a force to envelop and protect the patient, help the practitioner, remember directions given and guarantee financial support. In a western context, this would be done by a receptionist, lawyer, nurse, orderly, secretary and bondsman (Marriott, 1965).[13]

In western medicine, belief in disease causation often ranges from the microbial to excesses. Missing is the notion of an external agency such as a malevolent spirit or person. Also, missing in western medical care is the necessary recovery (even where it is common knowledge that recovery is not possible) which is often considered in indigenous terms essential to adequate treatment. Also considered essential is dietary advice, and a multiplicity of remedies may be applied as opposed to a single one.

As western medicine is regarded as having its failings, so too does indigenous medicine have its own. These include inability of patients to seek alternative treatment due to prohibition, fear, or undue conservatism, and the vulnerability of individuals or communities in the face of powerful or unscruplous practitioners. And some practices have been proved to be harmful.

Many rural communities consider certain diseases amenable to western treatment and seek relief of symptoms. But causation continues to be sought from indigenous sources which often offer a complex and detailed categorization.

Traditionally, western medicine has mostly held indigenous medicine in low esteem. Many of the direct links between them have occurred only when patients were brought to receive western treatment after indigenous methods had failed.

Today, indigenous health systems mostly exist alongside with western ones or are "filtered out" as a direct conflict of beliefs which result in their rejection or, they are synthesized with it in such a way that their beneficial aspects are retained to enrich the evolution of modern health care.

Health Education

Communities are helped to identify their health needs; and to select those which are likely to bring the greatest communal benefit synonymous with balanced local and national development.

Very often the health needs of the community that appear most obvious to the health personnel are not perceived at all by the community - they are "unfelt needs". In rural India, for example, the health personnel found that "in certain villages they just did not feel there was any need for medical care and were quite happy with what they had, the issue uppermost in the minds of the villagers was not health but food and water". (Arole, 1972).''

The issue of compatability of rural felt needs with national or agency plans sometimes continues to defy a satisfactory solution. Do communities, it is argued, ever really identify their needs? Or is there often a "charade" of needs identification and a "rubber stamp" of approval obtained for previously selected health plans? Often then, few resources are left for the longer-term aspects of improved health care.

The process of need identification following just one public meeting and a democratic "show of hands" is considered a poor substitute for the slower pace of systematic discussion. It has been found that rural communities in the latter case are more likely to choose a simple health post, than a multi-storeyed hospital.

But guidance is needed in order for communities to perceive that, to confront a single problem may involve attending to various needs. For example, improving the health of "under-fives" may require the provision of safe water, improved agricultural techniques, nutrition education, food storage techniques and fertility control.

Guidance is also needed with regard to financing desired health improvements and with regards to explanations of the national health priorities and resources. It is difficult to achieve the necessary balance between curative and preventive health care because the demands for curative care always seem to be more pressing.

Self-Help

By a process of self-help, communities are enabled to contribute resources and skills in pursuit of chosen objectives. Use is also made of voluntary organizations and of technical assistance at the local, national and international levels.

There is much that a rural community, however improverished, can provide in the way of resources for health activities. For example, for labour and leadership, manpower (especially where cultivators are only seasonally employed), inside knowledge of the community itself, and materials such as stone, wood, pottery and weaving can be provided. At the same time, self-help may not be a particularly cheap or easy method of improving health conditions. Indeed it may be more costly in terms of economy and time. During an African rural health center construction project, many problems intervened - disputes over the token wages, deaths necessitating mourning, heavy rainfall, traditional rivalries, etc. During the last stages of construction the whole labour force was engaged by the project (Sai, 1972).[18]

But there is evidence to suggest the self-help is often more effective in the long-term, as it affects many aspects of community life, guards against over-reliance on outside assistance, mobilizes community support, is an educational process and is related both to self-respect and self-determination.

In the Philippines, a free medical clinic for the poor evolved into a medical co-operative. Locally selected community leaders had met the medical staff and formulated a plan whereby the treatment costs were related to the peoples' ability to pay and to the cost of the medicines involved. Then "the people came to the clinic with clean clothes and scrubbed bodies. The end of the dole-out phase saw the commencement of a new pride among the people in themselves and in their medical co-operative". (Santiago, 1972).[19]

Outside assistance should encourage self-help, rather than take its place. For when aid is poured in from outside, the undertaking is not a demonstration of what communities themselves can do. As in the past, aid had been tied to projects acceptance and to donor agencies. Hospitals, on occasion, have been constructed where there were no personnel or resources to run them.

The pace of self-help may appear too slow where visible results are required by an external agency. But haste undermines real self-help, in that it seldom allows adequate time for the attitude changes fundamental to long term health improvement.

Community Leadership

Various types of community leaderships are identified and individuals, approved by the community, are selected to receive leadership training.

Rural leadership is often a vital factor in the success of health activities, where community leaders have perceived that these activities pose no threat to their own status. The identification and selection of leaders for rural health activities remains more an art than a science. Part of this art often consists of identifying certain personality characteristics allied to mental aptitudes and certain job-related skills. Those who have initially "rallied to the cause" have on occasion proved to be ineffectual leaders for health purposes, perhaps being self-ambitious or malcontents, with little community standing and limited enthusiasm. However, the more retiring "informal" or "opinion" leaders, such as the middle-aged mother of a large family to whom others automatically turn to for help, or the elderly respected religious leader, have proved to be of greater effectiveness. One aim, then of a comprehensive approach in rural health, is to promote action by groups within the community and by the community's own leaders.

In Nicaragua, one objective of a rural development program was to train village health leaders, "someone chosen by his own village with efficient education to be able to distribute common medicaments in accord with his judgement of common diseases and be able to administer injections for vaccination and TB programs, in far distant areas" (Oxfam, 1973).''

These leaders were supported by a medical committee comprised of villagers who supervised the ordering of medicine, payments of the leader, and co-operated with Government programs. This type of leaders is the precursor of the "village Health Worker" or VHW recommended by W.H.O.

Long Term Effectiveness And Minimizing The Disruptive Effects Of Change

In a community, few if any changes occur in isolation. Rather, they affect to some degree the whole community. Within this whirlpool of change, health activities which take the place of the interrelatedness of rural life, is generally ignored, their impact being minimal and their effect disruptive.

If, for example, a clean water supply is installed but disposal means are lacking, mud holes will appear and breed diseases; without trained personnel the machinery will fail . . . . . violence will be done to many social customs; women will be deprived of their social opportunities over wash tubs or youths may be deprived of courting opportunities at village wells (Foster, 1958).'' The "simple" supplying of clean water, is in reality, a complex innovation.

In practice then, "simultaneous involvement" inlcudes recognition of, for example, the fact that individuals and groups are part of kinship networks; that identification with one group often automatically incurs the opposition of rival groups who may refuse participation; that older people while resisting change for themselves may well accept it for their children (who are often more highly educated than their parents); that the use of friendship groups carries with it the extra safeguard of friendship against the possible disruptive effects of the change.

In many health activities, there is still a continuing tendency to regard change as good per se. In the light of experience past and present, that assumption can no longer stand. For it has been seen that, where disruptive change occurs it often provides a legacy of emotional and psychological disorders. In the process then of attempting to bring healing and health to the "body" of the community, much harm may inadvertently be done to its "mind". Special emphasis should be placed on the involvement of women due to their influence on family health and its role in community health.

In most developing countries children under the age of 15 years and women in the childbearing age (15-44 years) form over 60% of the total population.

If women are even to begin to play their full role in rural health activities, they first require to be in adequate health themselves. But many factors conspire to prevent this. These may include anaemia, parasitism, malnutrition, chronic ill-health, early marriage and constant childbearing, poverty, heavy manual labour, illiteracy, and lack of basic health care and fertility control opportunities.

Lack of adequate care during pregnancy, childbirth, and up until the next pregnancy - usually in the following two years, is often a central factor in the state of health of a rural women. Usually she receives care during pregnancy and delivery both from her kinswomen and from a "traditional birth attendant" who is often an elderly women of considerable community prestige, skilled to varying degrees in the art of birth attendance. In some countries, inclusion of these attendants in health programs has proved to be beneficial both to themselves and to their patients.

One approach to the problem of basic health care for rural women, is the African style "maternity village". This is situated near a hospital or health centre, and a woman, following outpatient anti-natal care, arrives prior to her confinement with her relatives who remain nearby to cook and care for her. Delivery and post-natal care is actually provided by supervised auxiliaries. Correct infant feeding and the care of children under five are emphasized in the educational measures, in which the mother and her relatives participate.

The Nigerian-style "under five" clinic is a further, particularly sensitive, approach to the relatives of the role of rural women.

"A whole day wasted waiting in the (average) clinic can still be spared by the African mother . . . . . who is a busy woman with a large family, food to grow, a husband to cook for and, only too often, her own living to earn . . . . . If she keeps her own child's record card, she need not waste time waiting for the clerk to find it nor need she wait at the dispensary if the nurses keep medicines on their tables". (Morley, 1966).''

In their roles as wives and mothers, the influence of women on family health is critical. The frequently have the power to reinforce - or sabotage-measures designed to improve community health. For example, the maintenance of latrines and wells often falls to them, and without their comprehension and support of these innovations, the unkept latrines and polluted wells become instead health hazards.

In a comprehensive community approach the role of women in rural health is not seen merely as one of passive enlightenment and mute support of others. Rather, in the industrious round of domestic and communal activities, a new more dynamic role emerges. (A minority will eventually assume more technical and bureaucratic roles). What is sought, is the self-development of rural women. But the low status of women is seen in some quarters as a hindrance to the attainment of this new role. However, estimates of status must be appreciated within their cultural context. The rural woman has many traditional and prestigious responsibilities both inside and outside her home, and weeding, pounding and water-carrying are not merely manual labour. In some societies the status of women have been considerably altered, these alterations having been brought about by socio-cultural change. For example, in Zulu society, where the absence of the menfolk as migrant labourers necessitated the caring of cattle, (traditionally a strictly male pursuit.) to be persued by the womenfolk.

The task of communicating with rural women is complicated by their often "enclosed" status which may necessitate making the first contact via their husbands or mother-in-law. Once trained for health activities, women have been found to be particularly beneficial, front-line workers in many patterns of basic health services. Their advice is readily acceptable in the community and they can easily adapt their approach to the local social, religious and cultural attitudes. They are also more "rooted" in the community often for domestic reasons, and less likely to be in pursuit of better employment.

Ongoing Research And Evaluation

Research and evaluation are considered an integral part of the approach. The importance of education is emphasized, and changes in attitude are considered as of similar and on occasion, of greater significance than material changes.

A physician, engaged in rural health in the Philippines, called research "a basic tool to re-orient and reformulate community medicine to meet the needs of the people" (Solon, 1970).[20] The treatment of the community patient can be monitored, treatment modified accordingly, and the information gained, used to enrich future treatment.

The value of research during or following health activities is commoner than that prior to their commencement. "There is usually a greater demand for data after a project comes to an end . . . . . headquarters and supporting organizations want to know what they got for their money (Hayes, 1959).[21] But "baseline" and "pilot" studies may well be crucial to eventual success. For example, if research had been carried out prior to the inaguration of an unsuccessful health insurance scheme for rural families, it would have emerged that the modest premium required, was even then too large for the improverished families to pay.

Much research of value for health lies strewn throughout many other fields, such as agriculture, education, anthropology and nutrition. Much data of importance for health deals with private thoughts, behaviour and attitudes. These things are hard to elicit and even harder to quantify. Research in community health is particularly difficult in that it often requires a range of skill and personnel which reach beyond those of the health personnel.

Past research has often been based on personal observations or on isolated small-scale studies from which it is hard to generalize. One problem is that research among those who attend as patients is not representative of the whole community, many of whom do not attend at all. In the words of a physician in a part of rural India, "There must have been 4000 deliveries each year, but we were taking care of only 300 of them - What happened to the remaining 3700 deliveries? (Arole, 1972).[22] For every patient that came for care 20 remained in the village."

For the over-worked health personnel, research often represents as output of time and energy which they find themselves unable, and often unwilling, to give. Some countries have enlisted the help of auxiliaries in various research procedures such as the compilation of statistics. But statistics and tables can tell only a part of the study of development. The self-respect and self-reliance that village people gain cannot easily be measured. But these changes are what makes future progress possible (C.D. Foundation, 1966).[23] Evaluation procedures, to be effective, should be determined at the planning stages of health activities and should proceed during its duration. The evaluation of health personnel themselves, is not usually carried out. Reasons for the success or failure of particular workers and projects are not always evaluated. In the past "pre-occupation with keeping services going often prevented in-evaluation of where one was going" (Helberg, 1972).[24]

Research and evaluation of health activities is crucial in most countries. Appraisal includes whether objectives are being achieved at the lowest possible cost and whether the benefits accruing are recognized as being greater than the cost (Hayes, 1959).[25]

Summary

From the common thread of past and present experiences in rural health activities, have evolved the concept and methodology of a "comprehensive community approach". This approach is particularly economical in that it emphasizes the use of the existing community resources auxiliary personnel and appropriate technology.

Where it has been employed, albiet partially, this type of approach has emerged as being particularly effective with regard to the achievement of both short and long-term objectives, integrated development, the avoidance of community disruption and in promoting the self-development of individuals.

In the past, where communities have succeeded in attaining improved health, little self-growth has occurred.

They have neither increased in self-knowledge nor in an ability for self-organization. Today, where a community approach does form part of the training curriculum of the health personnel, too often it consists only of a few lectures i.e. a fragment of the whole potential approach. To be effective, the principles and methodology of the approach requires to suffuse the whole training of health personnel and allied workers, of all categories.

"Despite current emphasis on community health and the need for the training of sub-professional personnel in developing areas, there still exists a feeling among some doctors and nurses, that public health is secondary to hospital medical care, and that the training of professionals is more important than training sub-professional health leaders . . . . . (These attitudes) are as difficult to change as traditional health beliefs because of their cultural and psychological aspects" (Mussalem, 1973).[26]

And the traditional physician is warned against the temptations of lacking "a little public health on to his traditional medicines. This can quiet any hunting concern that he may not be doing enough - and still allow him to continue pretty much as he was" (Sibley, 1971).[27]

In the words of the same director of a Korean rural health project "there should be a way to deliver the fruits of Western medicine without the burden of its frills".

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CHAPTER 8

COMMUNITY PARTICIPATION, THE NUCLEUS OF PRIMARY HEALTH CARE

Definition

"Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development"'

With its aim being, to increase personal and social responsibility for health, and at the same time, contribute to development, community participation is one of the principal strengths and supports of primary health care.

Socio-economic and health care development should start at the village level, and it is important that rural communities in developing countries participate closely in development programs. With some guidance, communities utlizing their own resources can organize themselves to achieve objectives that they have set. During the past decades, the success or failure of different "grass roots" schemes for primary health care has shown that testing results can be achieved only through community participation.

Forming a village health committee is one way of achieving community participation, enabling rural people to understand, through actual experience, the problems that can be solved with their own resources. A village health committee could be an important first step in the whole development process. By working together with the health personnel, its members can identify and analyse problems, set priorities, and draw up plans of action and implement them. With the support of such a committee, the primary health workers and the intermediate health personnel will have an opportunity to create, operate, and utilize the rural health care facilities in ways that are most acceptable to the community as a whole, and that meet their health needs.

A community's awareness of health matters should be continuously improved. The health personnel in rural health teams should be educators, initiating and stimulating the participation of community members in individual and community health care. This will increase self-reliance at the local level. Catalytic support from outside the community may be necessary, but the community should not wait passively for help to be given.

There must be a continuing exchange of views between the community representatives and the central health administration, so that the community's needs and goals can be assessed realistically. People are capable of doing much more for themselves to improve their quality of life if they are aware of their own potential for bringing about a better future.

If the local people at least partly control their health services, they will consider the health program as their own and will feel encouraged to make a greater contribution to its development, endeavouring to overcome economic, cultural, and political obstacles.

The primary health care approach requires that health-related activities be shaped and carried out in conformity with the life pattern, needs, priorities and capabilities of each community. This contrasts with a mere downward extension of the standard national health service practices which, in any event, has proved to be difficult and ineffective for a large majority of people in developing countries. The organizational structure of the health service will have to make a shift from drawing clients to a hierarchy of central service locations (thus limiting the numbers served and kinds of needs addressed) to an organization that essentially supports and provides back-up for services organized and performed in the communities. With this perspective of the health service structure, the center-periphery analogy becomes not only inappropriate, but smacks off a hold-over from conventional ideas of the past (even when more services at the "periphery" are advocated). The basic thrust of the primary health care approach is that the centre of gravity of the health system should shift from central urban locations to local rural communities.

Community Input

Communities, according to their capacity, need to mobilize human, financial, and material resources to supplement the resources provided by the national government and other extra-community sources in order to effectively carry out local health improvement efforts. Selected community members with a minimum of training, fully or partially supported by their respective community, are the front-line workers at the point of contact with the beneficiaries.

Role Of The Local People

In the preventive and promotive aspects of primary health care, the community people are the main actors, with the health service and the extra-community agencies playing only a supportive role. Collective and individual decisions and actions by community members, with appropriate assistance and input from the government, determine the effectiveness of their efforts with respect to sanitation, nutrition, environmental hygiene, supply and use of pure water, precautions against communicable diseases, and family planning.

Community Co-ordination

The primary health care approach recognizes that the health status of a community is affected by many non-health factors, including access to such essential goods and services such as food, clean water, shelter, clothing, and basic education. These factors together have more influence on the health and overall welfare of the people than all the measures that could be undertaken by the health service. Health care provisions constitutes a necessary, but not a sufficient condition for improving the people's welfare. The integration and co-ordination of the different sectoral activities necessary for making an adequate and sustained impact on health, can be brought about effectively only at the community level through community action and organization. It is evident that popular participation in health-related activities is the essence of the primary health care approach. It implies much more than passively benefitting from the government health service.

Dimensions Of Community Participation In Primary Health Care

A community, for the purpose of organizing a primary health care program or other development programs requiring strong community involvement, may be defined as a group of people which has a sense of belonging to the same entity, has a common perception of collective needs and priorities, and can assume collective responsibility for community decisions. The collective participation of communities in primary health care assumes different forms and varies widely in effectiveness and intensity. Major dimensions of community participation:

the organization of services on a community basis, with wide and easy access to the services - this may range from rudimentary services and a mere intention of eventual community-wide coverage, to adequate provisions for basic health needs and truly universal coverage of all community people; the contribution by the community to the operation and maintenance of the services - varying from small voluntary contributions in cash and in kind to supplement government and other external resources, to almost full coverage of costs through the systematic allocation of communal resources and individual payment:

the participation of the community in the planning and management of the services within the community, which may consist of only an informal and occasional consultation by health service workers with a few villagers, or the assumption of full responsibility for the program by a representative community body:

a community input into the overall stragegies, policies, and work-plan of the program, which may range from unsystematic efforts by well-intentional government officials to understand varying community situation, to a systematic arrangement for the participation of community people in policy making and planning at regional and national levels, and for regular feedback of pertinent program information from communities into the decision-making processes at different levels; the overcoming of factionalism and interest conflicts in the community in order to achieve a broadly based participation, particularly on the part of disadvantaged groups - the situations in this respect may vary from attempts to serve various sub-groups as equitably as possible, recognizing the reality of interest conflicts within the community, to the emergence of cohesive communities capable of engaging in cooperative efforts for the benefit of all.[2]

Obstacles To Community Participation

The recent studies of the primary health care program as well as the historical review of broader community development efforts, point to many obstacles in the way of cooperative community action for self-help and the growth of the participatory process.

Diversity Of Interests And Social Stratification

One basic problem is that group cohesion and the similarity of interests and perceptions necessary for a collection of people to behave like a community are far from being a universal phenomena. The rural areas of developing countries are often characterized by a highly uneven access to productive resources such as land, water, and capital; by a traditional social stratification and separation based on castes, by ethnic origin, religion, and sex; by political and economic institutions and by practices that reinforce the existing structure of privileges and create new privileged groups.

The "quack" medical practitioner, the usurious money lender and the large landowner may be the same person in the village; or if different persons, they will have a common interest in maintaining the status quo that preserves the system of privileges contrary to the interest of the rest of the villages. Even such a seemingly innocuous change as the introduction of community-selected health workers may pose a threat to the existing village power structure and open a flood-gate of social change, especially if the innovation calls for the democratic participation of all the village people - unless, of course, the whole process can be sufficiently controlled by the village "notables". The interests, priorities, and perceptions of problems of the different interest groups in the village may not be similar at all; in fact they may be in serious conflict.

The unhappy reality in many developing countries is that unless the structure of privileges and highly unequal social and economic relationships among the people are swept away by prior changes in the national political structure, the creation of a community spirit, the articulation of community aspirations, and the people's participation in the planning and management of community programs can progress only falteringly and in limited ways.

Projects are often cited, as examples of community participation, in situations where the national political system has not yet established the basis for cohesive communities and has not removed the barriers to community participation; however, sometimes a closer examination reveals that, even in these projects, community participation merely means giving a voice in local decisions to the local influential people, rather than to the most needy and the deprived who may constitute the majority. It may also be found that a disproportionately small share of the services and benefits go to the neediest. In other instances, community participation means seeking the local people's compliance with pre-determined central plans and programs, and extracting financial and other contributions from them, rather than a genuine partnership between the government agency and the people.

Administrative Resistance

Even when the general principles and objectives of primary health care and community participation are accepted in terms of overall national policies and goals, the tradition and attitudes prevailing in the governmental bureaucratic machinery often stand in the way of their translation into concrete action. This tradition is reflected in the unwillingness to de-centralize the administrative structure, to entrust authority and responsibility to community people and to make government programs and personnel accuntable and answerable to the people they are supposed to serve. This tradition, of course, is supported and maintained by the stratified social structure that separates the rural masses and the educated and relatively privileged people who man the government system, including the health services. It may be argued that the bureaucratic inertia and the inability to translate rhetoric into action are indications, of less than a full national commitment to a primary health care strategy with community participation, of an unwillingness to probe, understand, and accept the full implications of such a commitment.

Failure To Re-orient Entire Health Service To Primary Health Care

The primary health care approach can be undermined and communities can become victims of cynicism and despair, if the nominal adoption of the primary health care strategy leads to a dichotomy in the health service structure - "barefoot doctors" and "self-help" for rural people and the poor, and hospitals and medical specialists for town dwellers. It is not always easy for the health establishment and national decision makers to accept that the whole health service has to be re-oriented to the demands of primary health care and that the needs of primary health care must have the first call on national health resources. The surest way to discredit the primary health care approach and dampen community enthusiasm is by not providing adequate support to community-level activities in the form of supervision, training, essential supplies and an efficient referral arrangement.

Difficulty In Mobilizing People's Action

In situations where there is no tradition of community involvement in development efforts, and when adequate local government structures or other local organizations do not exist, it is a difficult and slow process to create the mechanism and motivation for community participation only in respect to health care. It becomes a pioneering effort, and so as to sustain the momentum and motivation, the organizers of the health programs must make an effort to extend community participation to other spheres of development.

The dilemma, however, is that the absence of local participating institutions in the first place can be usually traced back to a national, political and economic system that does not encourage decentralization of governmental responsibilities and does not offer the climate for active community roles in local development.

Footnotes

1 Mukherjee, B. Community Development in India, Orient Longman Ltd., 1967, New Delhi, pp. 16.

2 Ahmed, Manzoor., "Progress in Rural Extension and community Development," Vol.1 Edited by G.E. Jones and M.J. Rolls 1982, John Wiley & Sons, Ltd. pp. 255-269.

CHAPTER 9

PARTICIPATION IN SPECIFIC COMMUNITY DEVELOPMENT PROGRAMS IN INDIA - A LEARNING EXPERIENCE

Urbanization in India has accelerated so fast that it has overtaken the rate at which the general population is growing. The rapid pace of urbanization and the massive immigration of the rural and the semi-rural population in towns and cities have among other things, manifested themselves in two particular ways. Firstly, the process has produced a complex and difficult world of social relationships, coupled with a marked decline in effective communications and conflicting standards of behaviour. Secondly, it has increased the deficits and congestion of existing urban services, particularly in health, housing, education and civic amenities. It has resulted in the proliferation of slums which has assumed unimaginable dimensions. The municipal administration which has suffered a sharp decline in its efficiency and moral standards since independence, has no resources and skills to grapple with the stupendous problems of urban deterioration. Dissatisfactions and frustrations arising out of these conditions have serious repercussions on the stability of urban living.

Urban community development has emerged as a possible strategy of intervention to solve some of the problems of the city in general, and the depressed areas in particular. It involves two fundamental ideas: the development of effective community feeling within an urban context and the development of self-help and citizen participation in seeking community integration and change.

India's Urban Community Development Projects

In India, the first urban community development project was initiated in 1958 in Delhi with the help of a grant from the Ford Foundation. It was, subsequently, followed by the Ahmedabad (1962), Baroda (1965) and Calcutta (1966) projects. The Urban Relationship Committee Report (1966) did some detailed thinking on Urban Community development programs, making recommendations about the lines on which urban community development programs could be undertaken on a nationwide scale.

During the last year of the Third Five year Plan, the Union Ministry of Health initiated 20 pilot projects in selected cities with a population of 100,000 or more. Each project was designed to cover a population of 50,000, split into approximately 8 "mohalla" level committees with a population of 6,000 each, to be further subdivided into 12 primary units consisting of a small population of 500. The scheme provided a specific staffing pattern of a project officer and 8 community organizers supported by some voluntary workers for which a sum of Rs. 50,000 per annum was alloted. A separate grant of Rs. 15,000 was provided for local development activities undertaken by the neighbourhood community on the basis of a matching contribution. It was, however, decided that the expenditure would be shared on the basis of 50% to be paid by the Central Government and the remaining 50% to be met by the state government and the local body concerned. The expenditure on training, evaluation and research was to be met by the Central Government.

The Urban Projects

The original idea was to allocate at least one project to each state. However, only 14 projects were started in the first half of 1966 which are listed as under:

The response from the state governments was not very encouraging and in many cases, action in approving the start of a project was delayed and some of the states even abandoned the idea of sponsoring any projects because of the difficulties experienced in getting clearance of their respective Finance Departments due to constraints on resources. The Goa Administration decided to close down the project in 1968 followed by Rajasthan and West Bengal Governments in 1966. The Thansi Project was closed down in 1971 as per the recommendations of the Evaluation Committee appointed by the Government of U.P. Subsequently, 6 more projects were started at Surat, Tamnagar and Baroda (all in

Gujarat), Hyderabad (Andhra Pradesh), Quilon (Kerala) and Gauhati (Assam). (Table 1).

The urban community development projects were in the nature of pilot projects, designed to facilitate a very close concurrent study of the program as it developed while the broad guidelines were laid down in the light of the experience already gained. No attempts were made to prescribe any rigid uniform pattern at the initial stage. It was decided that the matter must be approached with a considerable degree of flexibility that would give a chance of studying and analysing the relative merits and demerits of the various methodologies and organizational patterns, so as to arrive at some proven set of workable patterns for the future. Keeping in view the experimental nature of the program, the scheme envisaged the provision of a good, strong cell at the centre with a necessary research staff which would visit the field frequently, gather information, analyse it, document the gathered data, and disseminate information among all the projects. The scheme had also provided for the appointment of a Director in each state, a senior level expert in social work, who would act as a guide and philosopher of the project in its formative stage and would be the program's eyes and ears in the field to register important messages in terms of field experiences. But somehow or the other, both these provisions could not materialize and the idea of in-built evaluation and research mechanisms in the program structure got defeated. Perhaps,

TABLE I

STATE	NO. OF PROJECTS	CITIES
1 WEST BENGAL	2	SALKIA AND TOLLYGANI
2 GUJARAT	2	BHAVNAGAR AND RAJKOT
3 U.P	2	KANPUR AND JHANSI
4 DELHI	2	SOUTH DELHI AND TRANS--JAMUNA
5 MAHARASHTRA	1	AURANGABAD
6 RAJASTHAN	1	AJMER
7 MANIPUR	1	IMPHAL
8 TRIPURA	1	AGARTALA
9 GOA	1	PANJIM
10 PUNJAB	1	LUDHIANA

this was one of the reasons the Ministry of Health was prompted to meet the idea of the program being evaluated by an outside expert agency.

The Evaluation Study

In September, 1971, the Ministry made a formal proposal to the Central Institute of Research & Training in Public Cooperation regarding the evaluation of the program. The following "terms of reference" were laid down for the evaluation study:

1. to examine and assess the overall impact of the project activities on the community in the project areas.
2. to study the nature and extent of community participation, the procedure of enlisting community participation and the impact of such participation on the attainment of objectives of the program; and
3. to find out difficulties and bottlenecks responsible for holding up more effective implementation of the program.

The study was carried out in the operational areas of those projects which were started in the year 1966-67. However only 7 projects were covered under the study which are listed in table II.

The Baroda Project was selected for a special observational study, as this project was operating on altogether different scales and patterns with different types and size of inputs. The listed seven projects were studied in their totality in order to obtain a comprehensive

TABLE II

NO	NAME OF PROJECT	
1	Aurangabad (Maharashtra)	Feb. 21,1966
2	Bhavanager (Gujarat)	Jan. 1, 1966
3	New Delhi South (Delhi)	April 20, 1966
4	Hyderabad (Andhra Pradesh)	Dec. 1, 1967
5	Kanpur (Uttar Pradesh)	Feb. 21, 1966
6	Ludhiana (Punjab)	Feb. 1, 1966
7	Surat (Gujarat)	Dec. 1, 1967

picture of the program. Besides, in each project, one Vikas Mandal service area or an equivalent operational area, was selected for a detailed and in-depth analysis of the projects' programs, their impact and people's participation.

The total size of the sample was 749 (107 for each project) and it included state level officials (7), project officials (35), residents belonging to the selected service areas (350), community leaders (98), beneficiaries of the selected project activities (245) and Municipal and Government Officials (14). The residents and beneficiaries of service areas, community leaders and project functionaries were interviewed with the help of specific tools designed for this purpose. Besides, detailed information about the structure and accomplishments of each project was collected through record proformas. The interviewing and record analysis were further supplemented by group discussions, participant observations and attending of meetings, etc. The data were collected during the period from October, 1971, to March, 1972.

Findings

The identification and selection of service areas for any development project involves issue of strategic significance as it very largely determines the action of the population which is to be reached and ultimately benefited. The central scheme laid down the following criteria for the selection of service areas:

1. these should be geographically contiguous, compact and part of a well defined administrative unit;
2. should have common characteristics regarding standards of development and services available in the area;
3. existence of specific plans for improvement;
4. availability of a community place (such as a school building, a library, etc.) in the neighbourhood to facilitate collective programs in the community.

Most of the service areas selected for urban community development work were in conformity with the criteria laid down and included slums and depressed localities of the city, new housing colonies where slum-dewellers had been shifted; and mixed bustees of 'Kautcha' and 'Purca' inhabited by low-income and lower-middle income groups. This has also been supported by the fact that more than 75% of the sample respondents belonged to the low-income group. However, the significant and crucial criterion of selecting only those areas for which the local authorities had specific development plans was not strictly followed in most of the cases. Consequently, the project staff had to undergo a lot of stresses and strains in arranging basic physical amenities for these areas. The criterion of geographical contiguity and compactness was also not observed in some cases such as in the Kanpur and Bhavangar Projects which led to placing heavy time-demands on the project staff and rendered the inter-service area's co-operation and co-ordination more difficult to achieve.

The project staff, in most of the cases, could not play a legitimate role in the selection of service areas and in a few cases the areas were selected when the project staff were away for their three months initial training. The project staff did involve themselves in surveying the potential areas, but their assessments were given less weight in preference to certain political or other consideration. In spite of these vitiating influences, the selected areas generally represented the slums and the depressed parts of the city habitat with the population falling in the low-income bracket.

Program Contents And Priorities

The central scheme listed six different categories of programs which could be taken up for the urban community development work. These program categories broadly were physical improvement and civic amenities; health and sanitation; economic programs; recreational and cultural activities; educational; and miscellaneous programs. The scheme laid special emphasis on motivation of the people themselves and on developing initiative amongest the people for undertaking programs that would meet their felt or expressed needs. It was further suggested that while the programs to be undertaken in a project will depend upon the needs and conditions of the area, it will be desirable to select only a few activities so that the project staff might concentrate on them and that their impact might become more visible.

The projects under study have undertaken a sizeable number of programs, of varied nature and content. The following table (Table III) gives the total number of units of activities under different program categories as reported by the six projects.

The figures suggest that unit-wise the largest concentration has been in programs of physical improvements and civic amenities and cultural and recreational programs, the latter also having the largest nature of beneficiaries. The programs have resulted in achievements of various natures and kinds. Through these programs, the projects have been successful, in that they have provided some basic physical and civic amenities, some essential health, educational and recreational facilities and have resulted in improving the socio-cultural climate of the service areas. The impact of these achievements was felt more by those who were either direct beneficiaries or were closely associated with the program's implementation. The table reveals that roughly 6 out of every 10 residents of the service areas have reported benefits accruing to them or to their family members from the activities of the project. As a by-product, these programs could also generate a few intangible benefits by way of fostering better inter-personal relationship, generating local initiative and increasing people's capacity to undertake self-help development programs. The confidence which was expressed in the ability of people to work

TABLE III

PROGRAM CATEGORY	UNITS OF WORK	NUMBER OF BENEFICIARIES
Physical improvement and civic activities	2118	112,700
Health and sanitation	727	311,589
Educational	374	120,582
Economic	695	41,675
Social, cultural and recreational	1629	472,588
Miscellaneous programs	89	32,619

* categories of programs with units and number of beneficiaries.

together on common problems had been substantiated.

However, the project programs were found to be too diversified in nature (a project listed some 82 activities under various program categories) and more often than not looked like a "copy book exercise" undertaken to follow the program outlines suggested in the central scheme. This robbed the projects of their own initiative in identifying local needs and problems, in determining priorities and in patterning the programs as suited to local conditions.

The economic programs, particularly, have failed to receive enough attention and emphasis. Both the residents and beneficiaries of the service areas voiced the need for undertaking economic programs time and again. Whatever economic programs have been undertaken were not backed by systematic planning, organizational ability or a viability of organizational and financial structures to handle production and marketing of goods. The economic programs, it seems, have suffered from the ad-hoc approach generally adopted by the projects in undertaking programs.

Community Participation

The concept of people's participation is central to the approach to urban community development. The entire process of urban community development is geared around people's involvement and participation in efforts to improve their level of living with as much reliance on their own initiative. Project programs have been conceived as mere instruments of initiating and enthusing the community for self-help through effective utilization of their own resources and mobilization of outside resources, which often lie well within their reach but go begging for want of co-ordinated efforts.

The residents of the service areas were generally aware of the project and its programs but their participation and involvement in project programs cannot be considered satisfactory. The following table (Table IV) classifies the residents in terms of their level of participation in project programs and activities. The table points out that only 38.1% residents (having high and medium level participation) can be described as having a satisfactory participation level, whereas the remaining 61.9%, have either a peripheral participation or no participation at all. This was primarily because project programs were not evolved out of the felt or expressed needs of the neighbourhood, and because the people's participation was not ensured from the very planning stage. Most of the participation was confined to receiving direct benefits and consumption of services only, and not much effort was made to extend it beyond that.

The central scheme recommended that each service area should have its own neighbourhood council (Vikas mandal) or 'Mohalla' committee consisting of representatives of different sections of the neighbourhood. The projects were supposed to help them evolve and grow and work through them

TABLE IV

COMPOSITE PARTICIPATION INDEX* OF RESIDENTS IN PROJECT PROGRAMS

Level of Participation	Percentage of Respondents
High	17.9
Medium	20.2
Low	30.8
No Participation at all	31.1

* The composite participation index refers to the participation score that each respondent could acquire in terms of his own and his family members' participation in project activities. This participation score was derived through measuring the respondent and his family's nature of participation, frequency of participation and the role they could play in the organizational structure of project programs.

in reaching the entire population of the neighbourhood. Some of the projects followed this suggestion in spirit, while many others proceeded a little too enthusiastically to form Vikas Sabhas and Vikas mandals. The result has been none too happy. In many a case, it has resulted in the creation of sterile, rootless and ineffective groups and organizations behind the facade of democratic leadership and initiative. This has been substantiated by the data which indicated that only one out of every four residents were members of such organizations. It seems that the formation of such bodies was not backed by sufficient prepatory efforts by the project staff, and the communities were not ready to accept and participate in these bodies which continued to exist artificially.

Training, Research And Evaluation

The central scheme had envisaged that the training, research and evaluation aspects of the program would be entrusted to a cell in the Central Ministry of Health. The cell was expected to be continuously engaged in the evaluation of pilot projects so that the successes and failures were duly analysed and lessons, to help in evolving suitable methods and techniques of field work, would be learnt. A three month training course was planned for the project staff before they took up their assignments. Provisions were also made for a regular training-cum-refresher course for the project staff, voluntary workers and local leaders. It was also proposed that short-term seminars and workshops be organized to orient regular minicipal staff in urban community development.

These mechanisms for training, research and evaluation could never strike roots in the program structure, if urban community development and the proposed research and co-ordination cell at the Centre would never get going. The skeletonic structure obtained at the Central level confined itself to financing, every year, a short duration refresher course for the project staff. Beyond that it did nothing. The concept of research and evaluation as a "service arm" to the program never developed and no systematic efforts were made to undertake staff-development program for want of supportive structures.

Summary

Urban Community Development is a relatively new and unexplored field of work. It has meant dealing with unstable communities living in frustrating and depressed conditions. There has been a lack of resources both from the point of view of the government and municipal funds and people themselves are too poor to pay for urban services. Development projects of the nature of urban community development programs carry no alchemic powers with mysterious potions. Nor do they have a magic wand to open the doors to wealth and prosperity. It is, therefore, not surprising that the results obtained from the working of urban community development projects are not spectacular. Nevertheless the projects have been able to make appreciable headway in sensitizing the people to their needs and problems, bringing their aspirations and discontents to surface, arousing their interest and enthusiasm for improving their conditions of living, helping people to organize a wide variety of programs of self-help, and mobilizing the support and assistance from various government and voluntary agencies.

There have been failures too, but they are largely accountable to such factors as very low inputs, lack of adequate structural support, interference from certain political and vested interests, general apathy and indifference prevailing among people, absence of proper supervision and guidance, inadequate provision of research and feedback mechanisms, etc. In spite of the mentioned pitfalls, the projects holds a promising future and has considerable potential in initiating a process of growth and change in the urban communities of India.

CHAPTER 10

COMMON PROBLEMS IN PRIMARY HEALTH CARE - DEVELOPING COUNTRIES

In most countries of the less developed world, resources for health - financial, manpower, facilities, planning and research - tend to be focused on the city and the large town, and within urban areas, resources tend to be part of the more complex levels of care. It is the hospitals and medical centers, caring for the few with diseases requiring the most complex technology, that have the greatest access to the resources of the country. This disparity in resource allocation between urban and rural areas and between primary care systems and the tertiary level is also characteristic of many developed countries. Because there is more money to spread around, the absolute level of expenditures for rural primary health care remains less abysmal. This concentration of resources on the more complex services and facilities, derives, at least in part, out of the medical profession's overwhelming pre-occupation with scientific medicine and with technology itself, and out of the human proclivity, often characteristic of those involved in political matters, to spend money for the largest, the "best", the "highest quality" and the "most advanced". The less visible primary level from its most peripheral point in the village to the larger health centers, is seen too often as not exemplifying those attributes, and as a result tends to suffer from financial undernourishment, underdevelopment and neglect.

The following list of common problem areas is not exhaustive. It is a starting point for considering ways of avoiding the difficulties in developing primary health action strategies.

1. Fragmented approach to health sector development

A fragmented approach to development has frequently resulted from the lack of resources to implement large programs. This direction has been encouraged by donors, international agencies and non-governmental organizations whose own purposes and limited resources often greatly influence decisions.

There appears to be a bias towards using pilot demonstration projects, for the developmental frame of project management, requires relatively small inputs, offering quick "results". Such projects rarely provide definitive and strong solutions to primary health care problems and usually cannot be replicated or significantly expanded.

There have been some notable successes such as promotives de salad in Columbia and Mexico, medicina simplificada in Venezuela, community health workers in India, health guards in Pakistan, the Solo project in Indonesia, the Chimaltenango project in Guatemala, and the Lampang project in Thailand. But the landscape of developing countries is strewn with the wreckage of demonstration project failures.

Governments often agree to donor-endorsed, donor-promoted manpower pilot projects without adequate examination of their long term implications. Since those projects often do not fit into the framework of the general health delivery system and are not capable of long term maintenance or duplication, they often collapse or quietly disappear because of problems with supervision, management support or training. This causes loss of confidence in primary health care at the national as well as at the village level.

2. Lack of a broad base of support for a national program.

Without a high level national commitment, primary health care programs will flounder. Without such a commitment, system changes necessary for national coverage (including improved organizational structures and strengthened management support systems) will not occur and ministries of health will have to seek politically expendient "quick fixes" rather than definitive solutions.

3. Obsolete organizational structures for the delivery of primary health care.

Traditional organizational structures perpetuate over-centralization and a "control" rather than a "development" perspective. They encourage the persistance of a narrow project approach, which focuses on closely controlled specific outputs and limited results, instead of a longer term development approach, which sets general goals and, through action planning, produces more significant and lasting result.

4. Inadequate management support

Management support for peripheral services based on the project instead of the overall program perspective does not promote development of lower and mid-level managerial capability. Nor does it promote such support systems as communications, information, supply, transport, personnel and financial management. If there is one single factor that can cause the failure of a development program, it is poor management.

5. Failure to develop a planning capability

Frequently, resource allocation for the various levels of a primary health care program is made without a planning and evaluation mechanism, thus undermining the institutionalization and permanency of primary health care.

6. Lack of overall manpower plan

Without an all-encompassing plan for harnessing the skills and knowledge of all categories of health manpower, nations are unable to optimize personnel training, development and utilization. Physician, nurses, and other professionals and technicians are often trained without a realistic plan for their most effective employment nor are they trained for linking peripherally oriented health workers with other health professionals. The isolation of primary health care from other health services reduces the effectiveness of all parts of the delivery system.

7. Ineffective and inefficient training

Numerous approaches used to train health personnel are arduous, time-consuming and produce health workers who are less competent than they should be. Many training programs are more concerned with the academic rather than with the practical. Traditionally, training is often concerned more with transferring theoretical knowledge than with developing adequate skills and problem-solving response patterns. Frequently, training occurs far from the workers's home and work place, influencing selection and reinforcing migration from rural areas. The training programs are explicitly concerned with how to achieve the knowledge transfer rather than with the skills development needed to do the job.

8. Lack of on-the-job continuing education

Skills deteriorate and no new skills are learned of the continuing education linked to ongoing supervision. Performance evaluation is not an integral part of primary health care from the beginning. Again, lack of personal contact adds to the health worker's sense of isolation and abandonment.

9. Failure to involve local community in national and regional primary health care programs

   Development strategies are often designed either "bottom up" or "top down", with the result that the link between the local community and other parts of the health system is not made.

10. Failure to utilize available community resources

    In developing countries, communities have vast untapped resources which could be utilized in the primary health care delivery system, examples of which are the traditional birth attendants, midwives, and traditional healers. If these community resources are utilized properly, the escalating cost of the health care can be controlled.

Action Strategies For An Effective Primary Health Care

It is necessary now to discuss a set of generic principles that can be used to develop effective action strategies.

1. Develop country-specific goals and objectives

   Initially, the long-range goal of a primary health care program should be established in terms of population coverage, health indices, and other relevant characteristics. By contrast, short term objectives should be carefully defined with schedules, resources needed, geographic coverage, and services being some of the determinants.

2. Obtain a national commitment

National commitment is absolutely essential for the development of a broad base of support for a primary health care action strategy, for the mobilization of resources, and for the co-ordination within and between the various sectors concerned.

3. Use of a systems approach to nationalize the delivery system

   A systems approach should be used to rationalize the organization of the primary health care delivery system and to relate it to the larger health service delivery system.

   a. integrate new primary health care activities into the existing institutional structures;
   b. improve the practical functioning of the relationships between the ministers and the public and private sectors;
   c. promote a development management perspective in place of a project management perspective;
   d. provide a basis for evaluating program operations in terms of achievement of program goals and objectives.

4. Encourage development of a primary health care planning capability

   A planning and evaluation system should be shaped to support primary health care. It should enable a ministry of health to formulate rational, coherent short and long term plans with other ministries, such as those dealing with economic development, planning and finance.

5. Develop a two/three tier primary health care manpower structure

A manpower infrastructure should be developed to train and deploy competent health workers for each level of health care. Each manpower tier could in term help train and supervise the subsequent levels, thus linking highly trained professionals at the center, with primary health care workers at the periphery.[1] Experience has shown that mid-level health workers can efficiently train and supervise community health workers, thereby reducing costs and other problems.

The greatest value of this type of structure is that appropriate and competent health manpower becomes permanently available all the way out to the periphery.

The funding possibilities for community workers are numerous. There may be village support on a fee-for-service basis as in the Piaxtla project, Mexico, or a village or district authority support as in the Solo project, Indonesia. The community workers may be part-time volunteers as in Nepal, or they may sell medicine, as in the Sine Saloum Project, Senegal.[2]

Another possibility would be for the villages to support curative services while the government funds for preventive campaigns. This approach would provide incentives for community workers to offer preventive as well as curative services, to the community.

6. Use of effective and efficient training methods

Varying approaches to training must be examined to determine which is most appropriate for a particular setting.

After examining the strengths and weaknesses of the most commonly applied educational processes, competency based training is viewed by many to be the most appropriate approach to training in primary health care. Competency based training has been found to be very appropriate for both mid-level and community health workers.[3] Of course, the methods chosen for imparting knowledge and skills to illiterate or semi-literate community workers differ from those used with literate health workers. The oral method is effective in training those with low literacy rates and is certainly perferable to eliminating the otherwise qualified people from the local candidate pool.[4] To-date, this technology has been adapted successfully in five different countries with a great saving in time and resources when compared to traditional approaches.[5]

7. Make continuing education a part of the strategy

If built into the action strategy from the beginning, and if integrated with supervision and management, continuing education can serve to reduce the time of initial training, upgrade job performance and prevent the decay of skills and knowledge. The content of continuing education should be progressively improved in the light of feedback from the field.

8. Use of mid-level health workers as critical links between the center and the periphery.

The UNICEF/WHO study on primary health care decision-making, puts community involvement into a contemporary perspective. In their citing of experiences in different socio-political environments, such as that of Costa Rica, Mali, Burma and Mazambique, a need to balance central and community inputs into primary health care is indicated.[6] There is an obvious need for a mid-level health worker, a "connector", to reduce the "distance" between the health center and the periphery.

The mid-level health worker can help to combine the development strategies that trickle down with those that percolate up.[7] By helping villages to mobilize primary health workers, and subsequently by supporting the direction exercised by villages over their health workers, the mid-level health worker can minimize many of the serious problems encountered when community health workers are isolated from other parts of the health system. Experience in primary health care from countries such as India and Nicaragua shows that the training, management, and supervision of community health workers require intervention by a mid-level health worker.[8] Such a worker can also relay the needs of the village to the center so that they can be integrated into area and regional plans. Properly trained, the mid-level health worker improves the accessibility, reliability, stability, and longevity of primary health care at the village level.

9. Use of country-specific primary health care strategy to plan resource allocation

The action strategy that results from using these principles favors the appropriate allocation of available resources and provides a comprehensive and rational basis for obtaining external resources. Such an action strategy can lead to a high-quality primary health care program that has a good chance of being cost-effective. An example of such appropriate resource utilization is the village support of the community health worker, who is often a traditional village practitioner.

Primary health care action strategies can work if they are based on sound principles and if available collective knowledge is brought to bear on a country's specific problem. Success in primary health care, thus, does not have to depend upon serendipity. It can be ensured by the open sharing of knowledge and experience by all who are working to improve public health and well-being.

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CHAPTER 11

STRATEGIES TO IMPLEMENT PRIMARY HEALTH CARE PROGRAMS THROUGH COMMUNITY PARTICIPATION

Assuming that there is a general acceptance at the national level of the primary health care strategy and of the importance of community participation, and that there is a willingness to re-orient existing policies and programs accordingly, a process can be initiated and a number of practical steps can be taken to enhance community participation in a primary health care program.

Re-orientation Of The Health Service Structure And Personnel

One essential step is the evaluation of the capacity and limitations of the existing structure for the delivery of primary health care, for the adoption of appropriate remedial measures, and for the instilling among the health service personnel of attitudes and perspectives in conformity with the principles of community participation and the new role of the health service. The most difficult task is not identifying the shortcomings of the present health service, or the changes needed in its organizational structure, but changing the attitudes and values of the personnel who have to implement the new mandate for the national health service.

An approach that should prove effective in bringing about the necessary change of outlook among the health personnel and at the same time in introducing the necessary reforms in the health services, is by engaging the health personnel themselves - from the top planners and managers in the ministry of health to the lower-echelon medical professionals in the field - in a process of self-appraisal and self-education. Small mixed teams of health personnel from the national and regional offices can go out to representative rural areas in the country to investigate the health status of the people, the performance of the government health service in relation to their basic service needs, the functioning of the traditional health system, the amount that villagers spend (or mis-spend) for health care, the opportunities for mobilizing financial and other resources in the village for health care, the existing village institutions as possible underpinnings for village-based and managed health programs, and so on. Personnel from individual health institutions such as the hospitals, research centres, training institutions, and departments and units of the health service can examine and analyse what they can do to re-organize themselves, to re-define their functions and goals, and to produce the needed manpower for implementing a primary health care strategy with community participation. The results of the investigation and appraisal can be compared and analysed to identify and formulate the plan of action at different levels and for different parts of the national health service. It would be as much a process of discovering the facts about the health services and preparing plans for the systems reform, as of re-educating the personnel.

Encouraged and prodded on by the minister of health, with the support of other top government and political leaders, and with appropriate guidance regarding the crucial health issues and the direction of change, the process of self-appraisal can become a kind of national movement from which can emerge a workable plan for a community-based primary health care system, as well as for the necessary health service personnel willing and able to guide the plan's implementation.

The Essential Elements Of Community Participation - An Analysis Of The Community

1. Study of the various groups within the community: the basis of selecting the aggregation of the population that can effectively organize itself for community participation, can be determined. Prevailing administrative units, natural geographical boundaries, and cultural affinity are important considerations in this respect. While existing social divisions need not be reinforced, factors which help generate a sense of community should be taken advantage of.
2. Survey of the community's resources and constraints: its general socioeconomic situation, the productive

resources and potentials, the status of the social services and institutions, the condition of the poor and the disadvantaged segments of the population, and the community's social structure, need to be studied. These factors will determine the environment of co-operative development efforts in the community, the nature of prospective involvement in development activities, and the potential for mobilizing the community's resources.

3. Survey of the community's health status and health care needs: basic objective information about the health situation - disease pattern, age-specific mortality, birth rate, sanitation and water supply, nutrition status, the nature and extent of available indigenous medical care - needs to be supplemented for by the population's subjective perceptions about the most serious health problems and the most urgent health care needs. This information would provide the basis for deciding on priorities for the community's health care programs and for organizing appropriate motivational and educational action.
4. Examination of the adjustments needed in the nationwide strategy for primary health care: a rigid nationwide uniformity of approach is neither practical nor is it in conformity with the principle of community participation. The diagnostic exercise should provide the basis for responding to the variations in the circumstances of the local communities within a

framework of national objectives and performance criteria.

5. Basic diagnostic tools: self-appraisal and dialogue. The diagnostic exercise should not become an elaborate social science research project - costly in time, money, and expertise, and beyond the means of local communities or even many national governments. At the initial stage, however, the health service personnel and other concerned agencies have to develop and learn a diagnostic methodology by engaging in a "learning-by-doing" process. The self-appraisal project mentioned above will provide a useful experience for this exercise. Social scientists from universities and research organizations with special interest in rural and community development can be of assistance.

Eventually, the diagnostic exercise should become a fairly simplified, quick, and relatively standard process carried out under the guidance of a local administration which is responsible for supervising the community health workers. This simplified diagnostic method can be applied to all communities as the community-based health care system expands nationwide. True to the spirit of community participation, local people should be extensively involved in the diagnostic process through formal and informal dialogues and discussions, and the findings and conclusions of the exercise should be validated and verified through this interaction.

Improving Modes And Mechanisms Of Participation

In situations where a community is a political and economic unit with wide jurisdictions over local government and productive activities, or where a strong representative local government body has substantial authority and responsibility for local affairs, the institutional structure for community participation with respect to health care already exists. In these situations, the main concern would be extending the benefits of the program equitably, making the participatory bodies truly representative, co-ordinating the health activities with other development efforts, and improving the overall quality of health care; in other words, improving the functioning of the existing participatory institutions.

Where the institutional structure does not exist or the local government body is without substantial authority, an appropriate participatory mechanism has to be devised or existing weak ones have to be rejuvenated. On the basis of a national appraisal and the local diagnosis, it has to be determined to what extent traditional and existing institutions, whether formally or informally constituted, such as village councils, neighbourhood associations, youth and women's groups, can serve the purpose; what modifications may be needed in existing institutions to ensure effective and fair participation; or whether new mechanisms are required. When new institutions need to be devised, initially, at least, the scope of participation will be narrow and limited to the health program. Eventually, these new institutions may evolve into multi-sectoral participatory organizations, provided the communities so desire and the government policies support such a move.

Local And Government Responsibilities

In all situations, opportunities and right conditions must be created for a free expression of views and genuine dialogue. It may be necessary for the health service and the community representatives to jointly set some guiding principles and criteria regarding democratic community representation and equitable sharing of responsibilities, obligations, and benefits. These criteria should not lead to frequent bureaucratic interventions in local program activities and the staffing of local initiatives. However, the health service or appropriate national government agency must ensure that the vital interests and rights of the weak and the needy in the communities are not violated by local decisions.

Educational Process

In addition to the usual health education activities, and distinct from the training and re-training of different types of health workers in the community, a continuous and vigorous educational effort is needed to get across to the people, (accustomed, on the one hand, to the bureaucratic neglect of their plight and, on the other hand, to a paternalistic hand-out approach in government services - the very premises of the primary health care approach) to the obligations and responsibilities of the government and the local people, to the principle of accountability of the program and its workers to the community, to the tenets of democratic participation and sharing of obligations and benefits, and to the need for the community people to organize and prepare themselves for greater self-management of community affairs.

This educational process does not necessarily require special "educational" activities; rather, an educational approach needs to permeate all the activities of the program. The participatory process itself through opportunities for dialogue, discussion, and involvement in planning and decision-making becomes an educational process - creating a critical awareness among the people, of the roots of their problems and approaches to tackling them. All the workers of the program must become educational workers as well, and the educational dimensions of all program activities must be identified and given recognition in the planning and implementation phase.

Preparing The Workers

The educational process, obviously, is not a one-way street. The program workers and organizers at the local level and above, also, have to learn to understand the local environment and the socio-economic structure, the ways of promoting and supporting local initiatives, and effective approaches for communication and education. The training and preparation of the community level workers and their supervisors have to take into account not only their technical tasks, but also their educational responsibilities. The workers have to be made aware of their educational role, encouragement and opportunities being given to them to play that role. Together the community and the program personnel must learn to work effectively to improve the people's health and welfare.

Co-operating With Voluntary Organizations

The special characteristics of small-scale non-government projects run by voluntary and non-governmental organizations, make them good instruments for testing and developing innovative community participation approaches that might be difficult and costly public programs. A practical way of facilitating the application of the lessons from these experiences to government programs would be for the government and voluntary organizations to embark on a "joint venture".

International Support

International, bilateral, and external assistance agencies supporting the adoption and implementation of the primary health care approach in developing countries, can enhance the effectiveness of community participation in various ways.

International assistance should encourage and support activities, with multiplier effects on the quality of community participation in expanding primary health care programs.

International support should be provided for activities which require international and regional co-operation, which are not easy for individual governments to undertake. Such activities may include regional and international exchanges of ideas and experiences through workshops, seminars, study tours, exchanges of training materials and other documents; and comparative reviews and analyses of regional and international experience in health care and community participation.

WHO and UNICEF, have taken the lead in promoting the primary health care approach, and in drawing attention to the role of community participation in the approach. Developing countries have begun to explore ways of co-operating with other UN and bilateral agencies in promoting the concept and practice of community participation for development.

It must be remembered that community participation is not an end in itself. The ultimate aim is to deliver better health care and to increase the people's welfare. This is the ultimate test that has to be applied in judging the value and effectiveness of participatory activities. Unless it contributes to the improved health and welfare of the community, the participatory process would become empty rituals and token gestures.

CHAPTER 12

A PROPOSAL FOR A COMPREHENSIVE STRATEGY

A minimal essential "health package" was launched publicly at a global health meeting in Alma Ata in the U.S.S.R. in 1979. Endorsed by all the member countries of the World Health Organization under the title of "Primary Health Care" (PHC), the new strategy emphasized a more equitable distribution of resources for health. Previously for example, as much as 80% of a total health budget had not infrequently been spent on a country's 20% urban population.

Eight essential components of PHC were identified: education concerning prevailing health problems and methods of preventing and controlling them; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; care for mothers and children including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

The PHC strategy also emphasized the importance of using appropriate technology. This includes using traditional health manpower such as traditional birth attendants and traditional folk practitioners. In addition it meant developing one of the hallmarks of PHC - the community health worker. The strategy also defined the concept health. Health according to the proposal is not the mere absence of disease; neither is it health services. Health is a balancing act, a continuous process of adopting to a changing environment." (United Nations)' It can also "enable imperfect man to achieve a rewarding and not too painful existence while coping with an imperfect world (Dube, 1958).' In this sense, the essence of health is how people approach the situation in which they find themselves.

While the PHC strategy acknowledges that health is only one of the whole complex of issues necessary to the provision of basic human needs, its relationship to these other issues is still far from clear. It is, for example, no longer assumed that "better health" will automatically lead to "better development". Neither can it be assumed that better development will lead to better health for the majority. Even with the development of self-help, self-care and community participation for health, there still remain essential attitudes, resources and policies which will determine the effective development of PHC strategies.

Seeing health more clearly in its socio-cultural, political and economic context, has helped workers, in what has often seemed to be the "separate" health sector, to recognize the interdependence of the various development sectors. Improved nutrition for example, may only be obtained in the long term by agrarian reform or changes in the food processing industries; a high infant mortality rate is related not only to poor health care services and to sickness, but also to lack of basic education for women; the provision of essential drugs supplies to community health workers requires adequate systems of communication and logistics; improvements in housing and sanitation requires the co-operation of the public works, social welfare and community development sectors.

The whole concept and practice of a community-based approach to health development, which is the foundation of Primary Health Care, owes much to the principles and practices of community development from the late 1960s and early 1970s. For example, issues common to the community based approach like the identification of local health needs, the analysis of the local social structure of the community, self-help, the utilization of indigenous technical knowledge, local leadership and local resources in partnership with the government, and the support of local people by the introduction of catalyst workers to assist the change process, are closely related to the principles of community development.

In a sense, community development techniques and approaches have been "borrowed" (in some cases long before Alma Ata), in order to achieve certain health objectives. Perhaps community development has been "used" rather than "understood". Many health professionals, for example, are unlikely to be able to describe community development as originally envisaged, or as it evolved. With a training rooted principally in the biological and medical sciences, some health personnel have been slow to embrace the concepts and practices of community approaches. In a sense, they were trained to "know the answers", not to assist others in searching for them. Even when the term "community diagnosis" is employed, the connotation is still largely that professionals, rather than the community, makes the diagnosis.

In general, the idea of community co-operation for health gave way to community participation, which in turn became community involvement. The latter is characterized by the involvement of communities not only in identifying health needs or in participating in activities chosen to remedy them, but also in decision-making, in planning and evaluating those activities. The central theme then, becomes one of "partnership" for improved health.

Originally viewed as an "extra" to the provision of basic health services or activities, community participation is now seen as a "prerequisite" and an "essential element," without which certain fundamental health activities cannot begin at all. For example, many national health ministries actually rely on large-scale community participation in order to fully implement their health plans. Optimally, these plans include "intersectoral cooperation", recognizing the interdependance of the various development sectors including community development.

In a study of emerging trends in community development, the United Nations found that projects undertaken without basic social and institutional reforms, restricted the benefits of development to a relatively small number of the population, not being reflective of the needs of the entire community but rather of the more articulate and powerful interest groups. This study concludes that community development might have to become an "instrument for radical change, even though this might create problems in terms of government support."(United Nations)[3] A similar conclusion was reached by Gunnar Myrdal in his book Asian Drama. He points out that lack of institutional reforms in village communities in India caused the ultimate failure of community development programs to benefit or include all members of society. Myrdal's call for basic reform of the social and economic structures (after agricultural development has been attained through capitalism) has been echoed fully a decade later by Bhattacharya and Sharma. In their study of India's rural development program after the Green Revolution, they conclude that:

"There is growing realization now that it is only through organized strength that the rural poor can hope to increase their capacity to resist exploitation, articulate demands and find a way out of the poverty trap" (Bhattacharya and Sharma).[4]

Biddle and Biddle, in their books on the community development process and the role of the "encourager", stress that the encourager "should not become a destroyer of the social order", but rather an expediter of fundamental changes in the people's ways of thinking. (Biddle and Biddle).[5] The Biddles consider co-operation to be the best means of building better communities, and suggest that rival groups within an area should work together towards a common good. (Biddle and Biddle).[6] If, however, social groups refuse to surrender privileges or advantages, let alone discuss working out a more equitable balance of power, then the encourager must admit "that the conflict is beyond his competence to handle." (Biddle and Biddle).[7] What happens after the encourager admits failure? Another problem arises, if modernization is seen by local communities as a threat to traditional standards; causing thereby serious obstacles and dissatisfaction to development. Neil Smelser warns that if these disturbed communities are denied access to influencing social policy - either through the isolation of the communities or through the intransigence of the ruling authorities - then demands for reform would tend to take a more violent form. (Dalton).[8] This would support the Biddle's claim tht one major purpose of community development should be to provide an outlet for people to be heard and through which they might participate in planning their future. (Biddle and Biddle).[9]

What happens, though, when governing bodies have no intention of sharing planning and decision-making powers with local participants? What is the result of community development projects aimed at band-aid solutions, designed to facilitate modernization and diffuse social tension? At the round-table conference in Mexico city, Jack Vanghu, who at the time was the Director of the Peace Corps, claimed that virtually no Latin American country looked at community development as a major vehicle for development; rather, "the best they have done to date is mild lip service" (Inter American Development Bank).[10] This statement was repeated five years later in the United Nations study, which found that national planners "may only play lip service to the principles of community development as regards to popular participation in planning, and may look on community development as a handy and ready-made mechanism for the implementation of national plans imposed from above (United Nations).[11] The whole question of motivation, therefore, ties in with the methods used to implement community development programs at the local level.

The true aim of community development is to encourage people to participate in local self-governance, thereby strengthening their capacity and sense of equity. Then perhaps the outcome of any community development program, promoted for whatever reasons by an outsider or an inside encourager, will be inevitable. Once local communities become persuaded of the power of organizing local initiative and self-help groups, then community development will be able to continue with or without the support of governments or international funding bodies.

To conclude, rural development is a mission and a liberating force. It is a thrust unravelling the potentialities of latent and overt institutional and attitudinal changes for the services of the rural poor. Efforts are being made to liquidate vested interests, which act as sieve preventing the benefits of development to percolate down to the disadvantaged groups. At best, all that it attempts, is growth with social justice. When that is achieved, the rural poor could, and would, resolve most of their problems themselves.

India's Present Planning In Primary Health Care

India is committed to attain the goal of health for all by the year 2000. It is a signatory to the Alma-Alta Declaration and to the Asian Charter for Health Development. Five working groups of experts were established by the Union Ministry of Health and Family Welfare to evolve a strategy for securing this objective. Furthermore, a working group of the planning commission had prepared the sixth five-year plan (1980-85) document for health and family welfare. The plan included a revised minimum Needs Program which incorporates:

1. Elementary education including adult education
2. Rural health and health guides scheme
3. Nutrition
4. Rural water supplies
5. House sites for the landless and rural housing

6. Environmental improvement of urban slums
7. Rural electrification

The targets of the rural health component of the Minimum Needs Program of the sixth five-year plan are given below:

1. Establishment of about 600 additional primary health centers. These additional centers will change the existing pattern of one primary health centre for 80,000 - 120,000 population to one (new) primary health centre for every 30,000 population. In the tribal and hilly areas, the population will be further reduced to 20,000. The new primary health centres will be established in a phased manner by upgrading the existing health institutions such as dispensaries.
2. Establishment of about 40,000 additional subcentres. The present norm of one subcentre for every 10,000 population is now changed to one for every 5,000. In the tribal and hilly areas, the population will be further reduced to 3,000 per subcentre. It is expected that by 1990 the entire country will be provided with subcentres according to this norm.
3. Establishment of about 174 community health centres. The earlier policy to establish a thirty bed rural hospital by upgrading every one of four primary health centres has now been discontinued. It is proposed to establish a community health centre for every 100,000 population in a phased manner. The centre will provide preventive,

promotive, and curative supportive services to the new primary health centres under its jurisdiction and also provide spcialist and referral services. Community health centres will be established by upgrading existing primary health centres.

4. Conversion of about 1,000 existing dispensaries into subsidiary health centres. Such centres will be eventually converted into primary health centres of the new pattern.

In addition, the sixth plan also provides necessary resources for quicker implementation of the Multipurpose Health Workers Program and the Health Aide scheme. For each new subcentre, i.e., for 5,000 or 3,000 population, a team of health worker (male) and health worker (female) will be provided. The program for training untrained dias (midwives) will continue, and by 1983 each village will have at least one trained dias. Since the second five-year plan, 304,562 dias have been trained.

The new type of primary health centres will be provided staff according to the original pattern with only one medical officer. However, the post of co-ordinator will be retained and a new paramedical cadre post of community health officer will be added. The function of this new non-medical health officer is to provide guidance, technical support, and supervision of the entire staff at the primary health centres and in the field. He will assist the medical officer in all his preventive and promotive functions and will also train the health guides.

"Health For All" now ceases to be the monopoly of the health services. An interdepartmental co-ordination committee has been formed. As mentioned earlier, effective and efficient health services will certainly contribute towards health promotion and welfare. However, integrated total developmental activities in other socioeconomic areas such as education, environmental protection, nutrition, etc. are indeed vital.

The task is stupendous. By the year 2000, the population of India is expected to be 917 million - 674 million rural and 243 million urban. Some say that it will even be 950 million. The targets set are reasonable, i.e., reduction of crude birth-rate to 21, crude death-rate to 9, and infant mortality rate to about 60. The task is difficult but can be done. A climate of optimism prevails.

Recommendations To The Primary Health Care Program In India

To define primary health care and its contents, it may be said that it provides the basic health care needs of any rural community through self-help and community development. It includes providing the health needs, (of any community wherever situated) namely:

1. Mother and child care including safe-delivery, ante and post natal care, and all measures concerning nutrition, growth and protection of the child from communicable diseases.

2. Provision and promotion of adequate nutrition for all people.
3. Adequate safe water supply and environmental sanitation measures such as housing, safe disposal of human and animal excreta, and control of insect breeding etc.
4. Immunization against prevalent communicable diseases.
5. Prevention and control of locally prevalent endemic diseases including appropriate early treatment of common diseases.
6. Provision of essential drugs.
7. School health educational programs.
8. Family planning measures to limit the growth of population.
9. Intensive health education measures to cover all the above aspects.
10. Employment of adequately trained technical and auxillary manpower for the entire program.

These health cases also involve, in addition to the health sector, the co-ordinated efforts of all related sectors and aspects of national and community developments, in particular, agriculture and animal husbandry, food, cottage industries, general education, public works and communication.

Also, in order to achieve the objectives, it will be necessary to promote maximum community efforts and self-reliance through participation in planning, organization, operation and control of primary health care, making the fullest use of local nationals and other available sources by giving them appropriate education to enhance their ability for effective participation.

The final aim being comprehensive health care, the primary health care system should be sustained by integrated functional and naturally referral system and team work, giving priority to those who need it most.

In India, the primary health care programs fell short to meet the principles set by the WHO (Appendix II) due to six reasons. They are:

1. Failure to provide the required health personnel, appropriate technology and drugs to meet the demands of the population.
2. The continuing shortage of resources due to economic slow-down, and socio-cultural characteristics of the community.
3. Failure to involve people in active planning and participation.
4. Improper allocation of health resources.
5. Reluctance of the Health Department to decentralize the administrative supervision and control.
6. Failure to integrate traditional health care practices into the existing health system.

In order to meet the requirement of the WHO principles of Primary Health Care, the primary health care system must be closely tied to a concern for total human development i.e. the holistic view of health encompassing the social, the physical, the mental and the spiritual well being of man. In fact, human development cannot be segmented, as all factors for human development and quality of life are interrelated. Efforts must be made to secure the fullest possible participation of the community in all aspects of the above processes. In this connection, it is again emphasized that appropriate forms of primary health care should meet the differing needs of the community, keeping in perspective a national balance between the curative, the preventive, the promotive and the rehabilitative components.

The government should also encourage and utilize the hundreds of well established and functioning voluntary organizations (both national and international) to carry out substantial health services through hospitals, dispensaries, clinics, camps, rehabilitation centres, and also through health education measures, so as to achieve health for all by the year 2000.

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APPENDIX 1

The Declaration of "Alma Ata" on Primary Health Care

1. Reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the applications of the relevant results of social, biomedical and health services research and public health experiences;
2. Addresses the main health problems in the community providing promotive, preventive, curative and rehabilitative services accordingly;
3. Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; and adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.
4. Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry education, housing, public works, communication, and other sectors; and demands the co-ordinated efforts of all those sectors.

5. Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care, making the fullest use of local, national and other available resources; and to this end develop, through appropriate education the ability of communities to participate.
6. Should be sustained by an integrated, functional and mutually supportive referral system, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.
7. Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically, to work as a health team and to respond to the expressed health needs of the community.

APPENDIX II

W.H.O's PRINCIPLES OF PRIMARY HEALTH CARE'

Primary health care should be shaped around the life patterns of the population it should serve and meet the needs of the community.

Primary health care is an integral part of the national health system and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support.

Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications).

The local population should be invovled in the formulation and implementation of health care activities so that health care can be brought into line with local needs and priorities. Community development workers should be involved in the health sector to meet community's decision making process.

Health care offered should place a maximum reliance on available community resources and the administrative structure should start from the community and up, that is the basis of primary health care programs.

W.H.O. Principles of primary health care were presented to the executive board of the World Health Organization which met in January 1975. EB/55/9.

Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

The traditional systems of medicine in the community which have been used for centuries in India, must be given due recognition. This would increase the availability of services to the rural population.